CANTERBURY DISTRICT HEALTH BOARD

2019-2023 STATEMENT OF INTENT

Incorporating the 2019/20 Statement of Performance Expectations

Statement of Joint Responsibility

The Canterbury District Health Board (DHB) is one of 20 DHBs established under the New Zealand Public Health and Disability Act in 2001. Each DHB is categorised as a Crown Agent under the Crown Entities Act, and is accountable to the Minister of Health for the funding and provision of public health and disability services for their resident populations.

This document is our Statement of Intent which has been prepared to meet the requirements of the New Zealand Public Health and Disability Act, Crown Entities Act, Public Finance Act and the expectations of the Minister of Health.

The Statement of Intent sets out our strategic goals and objectives, and describes what we aim to achieve in terms of improving the health of our population and ensuring the sustainability of our health system. It also contains our Statement of Performance Expectations for the coming year.

The Statement of Performance Expectations is presented to Parliament and is used at the end of the year to compare the planned and actual performance of the DHB. Audited results are presented in our Annual Report.

The Canterbury DHB has made a strong commitment to 'whole of system' service planning. We work collaboratively and in partnership with other service providers, agencies and community organisations to meet the needs of our population and support a number of clinically-led Alliances as key vehicles for implementing system improvement and change.

Our alliance framework means we share a joint vision for the future of our health system with our alliance partners and agree to work together to improve health outcomes for our shared population. This includes our large-scale Canterbury Clinical Network (CCN) District Alliance, with twelve local provider partners, the South Island Regional Alliance with our four partner South Island DHBs and our transalpine partnership with the West Coast DHB.

The DHB recognises its role in actively addressing disparities in health outcomes for Māori and is committed to making a difference. We work closely with Manawhenua Ki Waitaha, both directly and through the CCN Alliance, to improve outcomes for Māori in a spirit of communication and co-design that encompasses the principles of Te Tiriti o Waitangi.

In signing this document, we are satisfied that it fairly represents our joint commitment and intentions for the coming year, and is in line with Government expectations for 2019/20.

Dr John Wood
CHAIR | CANTERBURY DHB

Ta Mark Solomon
DEPUTY CHAIR | CANTERBURY DHB

David Meates
CHIEF EXECUTIVE | CANTERBURY DHB

September 2019

Table of Contents

Statement of Joint Responsibility iii

Foreword from the Chair and Chief Executive v

Part 1 Overview **1**

Who are we and what do we do? 1

Introducing the Canterbury DHB 2

Part 2 Long-Term Outlook **5**

What are we trying to achieve? 5

Our Strategic Direction 6

Our Immediate Focus 7

Part 3 Medium-Term Outlook **9**

How are we going to get there? 9

Managing Our Business 10

Building our capability 12

Monitoring Our Performance 16

Part 4 The Year Ahead **23**

What can you expect from us? 23

Statement of Performance Expectations 25

Statement of Financial Performance Expectations 35

Part 5 Appendices **46**

Further Information for the Reader 46

Appendix 1 Glossary of Terms 49

Appendix 2 Minister of Health's Letters of Expectation 2019/20 509

Appendix 3 Statement of Accounting Policies 54

Foreword from the Chair and Chief Executive

Canterbury remains a very challenging environment. We continue to deal with the ongoing impacts and underlying stressors related to a range of significant events that have affected our community.

- *4 September, 2010, Mag 7.1 earthquake*
- *22 February, 2011, Mag 6.3 earthquake*
- *13 June 2011, Mag 6.4 earthquake*
- *23 December 2011, Mag 6.0 earthquake*
- *2013 and 2014, Several Serious Floods*
- *14 February 2016, Mag 5.7 earthquake*
- *14 November 2016, Mag 7.8 earthquake*
- *13 February 2017, Port Hills Fire*

In March 2019, our community was exposed to another extreme and devastating event, when two Christchurch Mosques were the target of a terrorist attack that took the lives of 51 people and sent our city into lockdown.

We are proud to be part of a health system that stepped up in such a remarkable way to respond to the needs of the victims and their families. We want to thank our primary and community partners who collaborated to provide community support, and our Mana Ake teams who reached into school communities. We particularly want to thank our staff who worked tirelessly in the days and weeks following the attack to provide care in the most traumatic of circumstances.

We know from experience that the ongoing impact for the victims, families, Muslim community and some of our wider population will be a complex process and it will take time. The future wellbeing of our population is reliant on a responsive and flexible approach, informed by local need and supported by central government. As we move forward, we are working closely with other agencies and organisations to provide a locally-led and integrated wellbeing response, to ensure people get the help they need when they need it. Included in this work is the development of an online Resilience Hub, a central point for health and wellbeing support.

Committing to a sustainable future

In acknowledging our unique environment and challenges, we remain committed to an approach which recognises our strengths and continues to build a more integrated and resilient system. Our vision is simple, an integrated health system that keeps people healthy and well, in their own homes and communities. We are a connected health system, centred around people, and a strong platform exists for the next phase of our journey.

In moving forward, we are committed to working alongside the Ministry of Health to navigate the challenges our health system faces. The recent appointment of a Crown Monitor will help facilitate this, and represents an opportunity to ensure that the Government and the DHB are well aligned and to support the development of a sustainable operational pathway for the future.

The commissioning of our new facilities remains an essential element in our sustainability. We need to rebuild our lost capacity and enable investment in the infrastructure needed to meet the increasing demand for services as our population continues to grow.

The completion of the Hagley Building on Christchurch Hospital's campus will allow us to regain some of the capacity lost following the earthquakes, bring theatres back into operation, upgrade our intensive care and emergency departments, create much needed space for services and enable more integrated service delivery.

Before we can realise the efficiencies completion of this building will allow, we need to undertake the significant migration of existing services into the new building and the repatriation of outsourced services. New Zealand's largest ever hospital migration, it will be a sizable and incredibly complex piece of work for our teams in the coming year. Almost 3,000 staff and up to 300 patients will need to migrate into the new building over a two-week period.

Approval for the construction of the new mental health facility on the Hillmorton campus will allow us to relocate services stranded on The Princess Margaret Hospital site and make significant improvements in the experience of mental health consumers, their families and our staff. The planning and design phases have commenced and the new facility is expected to be complete by 2023.

Collaborating for better outcomes

In the coming year we will focus on service efficiency and improving the flow of patients across our system to reduce the pressure on specialist services. We will work with our primary care partners to implement the Government's direction for primary mental health care and continue our commitment to cross-sector collaboration, including the Mana Ake initiative in schools to improve the wellbeing of our young people and ACC partnerships to reduce harm and enhance recovery. We will also be looking to build community capacity to further support the integration and delivery of services such as: palliative care, mental health and addiction services, maternity services, rural health services, community nursing, restorative care and rehabilitation.

As the largest health service provider in the South Island, we will continue to work with our regional counterparts, particularly the West Coast DHB as part of our shared transalpine model, to support the delivery of services and progress regional priorities outlined in the South Island Regional Health Services Plan. We will also continue to support the roll-out of regional information systems and solutions, including the South Island Patient Information Care System (PICS). When fully implemented, this single shared electronic system will help to simplify access to patient information and support improved clinical decision making, no matter where in the South Island a person is treated.

Addressing equity

In the coming year, we will build on our partnerships with our Māori and Pacific providers and Whānau Ora agencies, to provide communities with access to the services they need earlier, and improve the health and wellbeing of our Māori and Pacific populations. Working together we are strengthening our focus on actions that eliminate inequities. These actions are outlined in our Annual Plan and System Level Measures Improvement Plan, companion documents to this Statement of Intent. To support this work, we are also deliberately investing in strategies to build a workforce that better reflects the diversity of our community.

Supporting our people

In supporting our community's recovery, we need to ensure that we have strong teams in place. We will progress the implementation of our People Strategy to create an environment where our people can thrive. In supporting the health and wellbeing of our staff, we will also look to address growing sick leave rates to contribute to a more sustainable future.

As always, we remain focused on continuing to deliver high quality care to our community. We know that we could not achieve what we do without the ongoing support of our people, both those who work for and those who work with us. We look forward to working alongside you in the coming year to make it better for the people of Canterbury.

David Meates
Chief Executive

John Wood
Chair, Canterbury DHB

September 2019

OVERVIEW

Who are we and what do we do?

Introducing the Canterbury DHB

1.1 Who are we

The Canterbury District Health Board (DHB) is one of twenty DHBs in New Zealand, charged by the Crown with improving, promoting and protecting the health and independence of our resident populations.

In 2019/20, we will receive approximately $1.945 billion dollars from Government with which to meet the needs of our population. In accordance with legislation and consistent with Government objectives, we use that funding to:

Plan the future direction of our health system and, in collaboration with clinical leads and alliance partners, develop demand strategies and determine the services required to meet the needs of our population.

Fund the health services required to meet the needs of our population and, through our collaborative partnerships and ongoing performance monitoring, ensure these services are safe, equitable and effective.

Provide the health services to our population, through our hospital and specialist services, general practices, and community and home-based support services.

Promote and Protect our population's health and wellbeing through investment in health protection, promotion and education services and the delivery of evidence-based public health initiatives.

1.2 What makes us different?

The Canterbury DHB has the second largest population of any DHB in the country. In 2019/20 we will be responsible for 578,340 people, 11.6% of the total New Zealand population.

We own and operate six major facilities: Christchurch, Christchurch Women's, Hillmorton, Burwood, Princess Margaret and Ashburton Hospitals, and many smaller urban and rural facilities, and cover the second largest geographical area of any DHB - 26,881 square kilometres and six Territorial Local Authorities.

We are the largest trauma centre in New Zealand and the fifth largest in Australasia. We deliver the second largest number of elective (planned) surgeries in the country and deliver half of all the elective surgery provided in the South Island.

We employ more than 10,700 people across our service divisions and facilities, making us the largest employer in the South Island. We also hold and monitor over 1,000 service contracts and agreements with other organisations, agencies and individuals who provide health and disability services for our population. This includes: general practice; pharmacy; laboratory; maternity; child health; personal health; mental health; dental; residential and aged care service providers; private hospitals; and the three Primary Health Organisations in Canterbury.

1.3 Our regional role

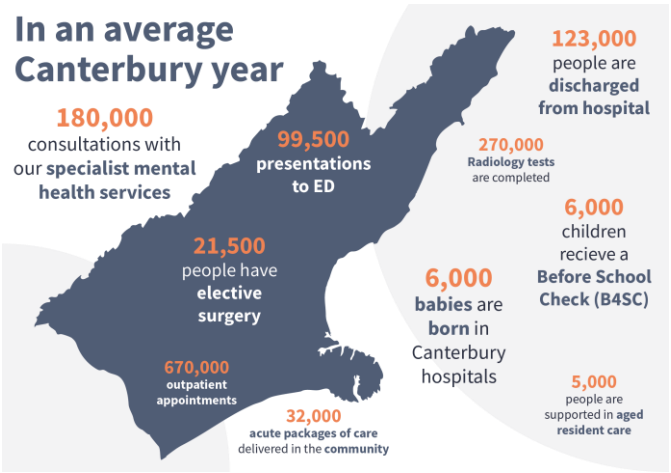
As the second-largest tertiary service provider and the largest trauma centre in the country, Canterbury provides an extensive range of highly specialised services to people from other DHBs where the service or treatment is not available.

This regional demand is complex in nature and growing steadily. In the five years to June 2017, there was a 9.5% increase in hospital admissions and a 15.5% increase in outpatient appointments for people referred by other DHBs. In 2017/18, almost 7,000 people from outside of Canterbury were discharged from one of our hospitals and we provided over 61,155 outpatient appointments to people from other DHBs.

The services we provide on a regional basis include: brain injury rehabilitation, child and youth inpatient mental health, eating disorder, neonatal, cardiothoracic, neurosurgery, endocrinology and forensic services. We are one of only two DHBs in the country providing paediatric oncology, acute spinal cord impairment surgery, hyperbaric oxygen therapy and specialist burns treatment. Our laboratory service is also one of only two tertiary level laboratories in the country and in a typical year delivers over four million diagnostic tests, informing 60-70% of the clinical decisions made across our health system.

A formal transalpine service partnership established with the West Coast DHB, means our specialists provide regular outpatient clinics and surgical lists on the West Coast. This arrangement enables more equitable access to highly specialised services for the population of the Coast and supports improved workforce planning between both DHBs. The West Coast and Canterbury DHBs have shared operational resources since 2010. This includes a joint chief executive, executive directors, clinical leads and corporate service teams.

Since 2015, we have also been responsible for the Chatham Islands (840 kms east of Christchurch) with a population of just over 600 people.



1.4 Our population profile

The Canterbury region has undergone rapid population changes post-quake. Despite an initial dip and a redistribution of our population, we are now experiencing a greater growth rate than was predicted prior to the earthquakes.

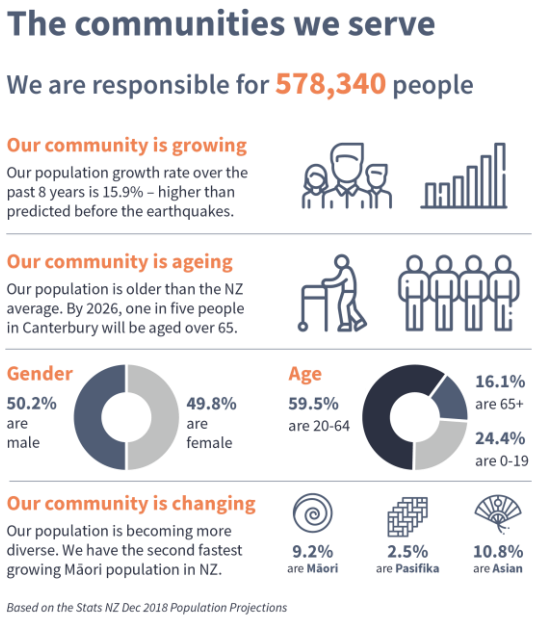
There has been a 15.9% increase in our population over the past eight years. We had not anticipated reaching current population levels until 2025/26.

Our population is older than NZ as a whole and Canterbury has the largest number of people aged over 65 in the country. The latest population figures show 16.1% of our population are aged over 65, a total of 93,150 people. By 2026 one in every five people in Canterbury will be over 65.

Many long-term conditions become more common with age, including heart disease, stroke, cancer and dementia. As people age they develop more complex health needs and are more likely to need specialist services. Our ageing population will put significant pressure on our workforce and infrastructure.

We also know that some population groups have less opportunity and are more vulnerable to poor health outcomes than others. Ethnicity, like age and deprivation, is a strong predictor of need for health services. Canterbury has the sixth largest and second fastest growing Māori population in the country. There are 53,300 Māori living in Canterbury and by 2026 Māori will represent 10% of our population.

Our Māori and Pacific populations have much younger age structures, with 11% of our Māori and Pacific populations aged under five, compared to 5.9% of the total population. There is a growing body of evidence that children's experiences during the first 1,000 days of life have far-reaching impacts on their health, educational and social outcomes. In supporting our population to thrive, it will be important to focus on our younger Māori and Pacific populations.



1.5 Our population's health

Canterbury's population has very similar life expectancy (81.5 years) to the New Zealand average (81.4 years). Differences continue to exist for Māori compared to non- Māori. Māori have poorer overall health and a lower life expectancy (79.1). However, the equity gap for life expectancy in Canterbury is reducing at a faster rate and at 2.4 years is considerably smaller than the national gap where Māori life expectancy (75.1) is almost 6.3 years lower than the total population.

The increasing prevalence of long-term physical and mental health conditions is one of the major drivers of demand for health services and the main cause of health loss amongst adults. This is also true for Canterbury where an increasing number of people are living with long-term conditions such as cancer, heart disease, respiratory disease, diabetes and depression.

A reduction in known risk factors such as smoking, poor diet, lack of physical activity and hazardous drinking could dramatically reduce pressure on our health system and greatly improve health outcomes for our population. All four major risk factors have strong socio-economic gradients, so population health interventions that reduce these risk factors will also contribute to reducing health inequities between population groups.

The most recent combined results from the 2014-2017 New Zealand Health Survey found that:

- 28% of our adult population are classified as obese and rates amongst our Māori (46%) and Pacific (59%) populations are significantly higher.
- 20% of our adult population (one in five). identified as likely to drink in a hazardous manner
- 15% of our total population are current smokers with smoking rates for our Māori (40%) and Pacific (37%) populations significantly higher.
- 11% of our total population identified as inactive (having little or no physical activity). Māori (12%) and Pacific (15%) rates are slightly higher.

EARTHQUAKE AND MOSQUE ATTACK IMPACTS

While new research indicates some sections of our population are coping with the psychological impact of the earthquakes and thriving in their lives, there is increasing divergence in our community with a marked increase in demand for mental health support. The NZ Health Survey reported that 23% of our population have been diagnosed with a mood or anxiety disorder, compared to 19% of the population nationally.

This has been further exacerbated by the March 2019 mosque attacks, when our community was exposed to another extreme and traumatic event. The immediate response of our health services was exemplary, acute operating theatres at Christchurch Hospital running non-stop for 24 hours and staff working overtime to treat and support the victims and their families. General practice and primary mental health teams collaborated to provide free and streamlined support,

and our Mana Ake programme provided a platform to reach into school communities to distribute information and to provide immediate guidance, determine need, and respond accordingly.

We know from experience that recovery from disasters and emergencies is complex and takes time. The ongoing impact for the victims, families, Muslim community and some groups of our wider population will be longer-term. The health impacts for children are particularly worrying and supporting their wellbeing is a major focus for our health system.

1.6 Our unique operating challenges

Like health systems world-wide, the shared challenges DHBs are facing are well understood. Populations are ageing, service demand is growing, and meeting increasing treatment and infrastructure costs and heightened expectations around wage and salary increases, are an ongoing challenge.

While Canterbury has made real inroads in achieving a truly integrated health system, meeting the health needs of a large population is complex. Progress is hampered by the unique operational challenges we continue to face following the earthquakes.

POPULATION PRESSURES

Following the earthquakes, our population growth has been rapid, with a 15.9% increase over the past eight years. While this population growth is positive for our economic recovery and confidence in the region, it is a major challenge for our health system. Our population has also spread out across the region with Selwyn, Waimakariri and Ashburton being three of the fastest growing districts in the country. We are working hard to find a balance between the increasing needs of our growing population, and the workforce, infrastructure, and funding resources at our disposal.

DEMAND PRESSURES

Service demand patterns have changed. Prolonged levels of stress and anxiety are exacerbating chronic illness and negatively impacting on the health and wellbeing of our population. Increased demand is evident across our system, particularly in mental health services. We have implemented a number of intervention strategies to reduce this growing demand, but it remains a significant issue. Our health system is at full capacity and resources are stretched.

As a major tertiary provider, we are also dealing with an increasing level of demand for highly complex and resource-intensive services from neighbouring DHBs, with a 9.5% increase in hospital admissions for people from other DHBs over the last five year. Our theatres, intensive care, radiology and oncology services are under particular pressure. These factors also place additional pressure on our workforce.

FACILITIES PRESSURES

The earthquake damage to our infrastructure was extensive and repair strategies are not simple. We lost more than 44 buildings and are having to cope with fewer hospital beds and a shortage of theatres. Ongoing delays with major redevelopment projects have added to the pressure and Christchurch Hospital's Hagley Building (Acute Services) is still not complete. We are hiring private theatres for our staff to work in and outsourcing more and more surgeries, to meet service demand, the increased service costs are significant. Construction delays and disruptions place considerable pressure on staff and budgets.

Our growing population, changing service demand and increasing regional service expectations are compounding this pressure. The Hagley Building alone will not provide sufficient capacity to meet our population's needs and further investment will be required. A number of facilities are also damaged and need repair, but are reaching the end of their functional life. We are working hard to ensure the safety of our patients and staff, but the future of all of our facilities needs to be firmly determined.

WORKFORCE PRESSURES

Our Staff and Family Wellbeing Survey results show that people are engaged and believe they are making a difference, but they are weary and staff commitment is being tested. Sick leave rates have risen rapidly and are now among the highest in the country. This view is reiterated by providers from across our health system, equally concerned about the wellbeing and resilience of their workforce.

The DHB is working hard to maintain a safe environment and ensure the wellbeing of our staff, particularly as we shift people, patients, and services to repair and redevelop facilities. We have implemented a number of initiatives to mitigate disruptions, however construction noise, service relocation and parking issues are causing increasing stress for staff and patients alike.

FISCAL PRESSURES

Our fiscal pressures are also compounded by the extraordinary impacts of the earthquakes. Increased earthquake-related operational costs are evident in a number of areas including treatment costs related to increased health need, outsourcing costs to cover lost theatre and bed capacity and multi-year construction delays. The DHB is also meeting substantial depreciation and capital-related charges associated with the repair of damaged buildings.

While a careful programme of repair is underway, it is apparent that a considerable portion of our earthquake repair work will not be covered by our insurance proceeds. The DHB's normal capital expenditure and maintenance budgets will not be enough to cover repair costs and to address capacity constraints as our population continues to grow.

LONG-TERM OUTLOOK

What are we trying to achieve?

2

Our Strategic Direction

2.1 The Canterbury vision

Eleven years ago, health professionals, clinical leaders, consumers and key stakeholders came together to rethink the future of the Canterbury health system.

We knew we needed to do things differently and we needed to work together to address our collective challenges. Together, we committed to a vision that recognised our future was not just about hospitals, but about everyone working together as one team to do the right thing for both the patient and the system.

Our vision is an integrated health system that keeps people healthy and well in their own homes and communities. A connected health system, centred around people, that aims not to waste their time.

Our vision is underpinned by three strategic objectives:

- The development of services that support people to stay well and enable them to take greater responsibility for their own health and wellbeing.
- The development of primary and community-based services that support people in the community and provide a point of ongoing continuity, which for most will be general practice.
- The freeing-up of hospital-based specialist resources to be responsive to episodic events, provide timely access to more complex care and specialist advice to primary care.

OUR PERFORMANCE STORY SO FAR

In working to deliver on our vision, we are doing things differently. We re-evaluated our relationships with health providers, and with the people we care for. We've become more integrated, more connected and we've reduced waste and duplication.

By enabling clinically-led service design, integrating service delivery models and expanding the role of primary and community providers, we have been able to moderate the growth rate in acute demand for hospital services. We have also been able to significantly reduce the proportion of people living in aged residential care and reduce their length of stay, creating savings which have been used to better support people in their own homes and communities.

Like some of the more innovative health systems around the world, a cornerstone of our success has been the redesign of shared clinical pathways and service delivery models, to address service gaps and improve access to the right services at the right time. Connecting information systems and sharing data has also been a key enabler of change. Access to real-time information, at the point of care, is helping us to improve the quality and safety of the care we provide and is reducing the time people waste waiting.

Engagement with health services is positive. At the end of 2017/18, 93% of our population were enrolled with primary care, 95% of eight months olds were fully immunised and we have the lowest acute medical admissions in the country. Despite capacity constraints, we delivered 21,402 elective surgeries, 72 more than our national target, 96% of people waited less than four months for treatment and 94% of people received their surgery on the day of admission.

2.2 Nationally consistent

Our vison is closely aligned to the Government's long-term vision for New Zealand and for the health sector, as articulated through the NZ Health Strategy with its central theme 'live well, stay well, get well'.

It particularly reflects alignment with the Government theme 'Improving the well-being of New Zealanders and their families' and the priority outcomes: Support healthier, safer, more connected communities; Make New Zealand the best place in the world to be a child; and Ensure everyone who is able to, is earning, learning, caring or volunteering.

The Minister of Health's annual Letter of Expectations also signals priorities and expectations for DHBs. The expectations for the coming year signal a strong focus on equity in health and wellness.

The priorities emphasised for 2019/20 are:

- Improving child wellbeing;
- Improving mental wellbeing;
- Improving wellbeing through prevention;
- Better population health outcomes, supported by a strong and equitable public health and disability system;
- Better population health outcomes, supported by primary health care;
- Strong fiscal management.

The DHB's Annual Plan outlines how we will deliver on the Minister's expectations in the coming year. The Minister's Letters of Expectation for 2019/20 are attached as Appendix 2.

2.3 Regionally responsive

There are five DHBs in the South Island (Nelson Marlborough, Canterbury, West Coast, South Canterbury and Southern) and together we provide services for over one million people, almost a quarter (23%) of the total NZ population.

While each DHB is individually responsible for the provision of services to its own population, we work regionally through the South Island Regional Alliance to address our shared challenges and develop more responsive and effective health services.

Our jointly developed South Island Health Services Plan outlines our regional direction, priorities and agreed work programme for 2019-2022. There are six regional priority focus areas: Data and Information; First 1,000 Days; Mental Health; Acute Demand Management; Social Determinants of Health; and Advance Care Plans.

Canterbury DHB has made a strong regional commitment and is engaged in a number of work streams including: cardiac, child health, older person's health, major trauma, mental health, cancer, stroke, telehealth, public health, oral health, and workforce.

Canterbury also takes the lead for Information Services regionally, including development of HealthPathways, HealthOne and the rollout of the South Island Patient Information Care System (PICS). These shared electronic systems help to simplify access to patient information and support improved clinical decision making, no matter where a person is treated.

The Regional Health Services Plan can be found on the Alliance website: www.sialliance.health.nz.

2.4 Committed to achieving equity

Not everyone living in Canterbury experiences the same health outcomes, and some people experience advantages and opportunities that others do not.

Social determinants such as education, employment, housing and geographical location can impact on opportunity as can aspects of a person's identity including age, gender, ethnicity, social class, sexual orientation, ability or religion. Equity is about fairness and we are committed to achieving equity in health outcomes particularly for Māori and Pacific people who currently experience poorer health outcomes.

Acknowledging and taking steps to address inequities in our system can be confronting and challenging, but is necessary if we are to progress towards equity. By making this commitment we acknowledge that we will need to evolve our workforce, build health literacy and cultural capabilities and redesign service delivery models, to better meet the diverse needs of all the people in our community.

The DHB's planning is guided by a range of national strategies, including: He Korowai Oranga (the Māori Health Strategy), Ala Mo'ui (Pathways to Pacific Health and Wellbeing), the Healthy Ageing Strategy and the NZ Disability Strategy. We are also supported by tools such as the Health Equity Assessment Tool (HEAT) to assess, identify and address disparities.

Actions to deliver health equity are identified throughout the DHB's Annual Plan for 2019/20.

Our Immediate Focus

While we have achieved significant momentum, progress has been hampered by the unique operational and population health challenges we have faced following the earthquakes. Population growth across all population groups is also driving associated service demand across our system.

Our planning forecasts show our health system is at full capacity. Sustaining current service levels and meeting demand through the coming winter will be a significant challenge; we do not have enough acute hospital beds to meet forecasted demand.

To keep our system operating, and meet immediate service demand within current resources, we need to manage our business well, keep people connected and identify opportunities to reduce duplication and waste.

Because resources are increasingly limited, we also need to continue to work collaboratively, across both health and social services and between DHBs, to ensure our investment is directed into activity and services that will provide the greatest impact.

Three Strategic Themes highlight the factors seen as critical to our immediate and long-term success.

KEEPING OUR HEALTH SYSTEM OPERATING:

- Maintaining our whole of system approach
- Improving the flow of patients across the system
- Supporting the commissioning of new facilities

SETTING THE DHB UP FOR FUTURE SUCCESS:

- Creating a sustainable pathway forward
- Investing in an effective People Strategy
- Delivering on our Digital and ICT Transformation
- Completing a masterplan for Christchurch Hospital

CONTRIBUTING REGIONALLY & NATIONALLY:

- Supporting industrial negotiations
- Delivering on new service expectations and policies
- Responding to vulnerable service challenges

In the coming years the DHB will continue to focus on service efficiency and improving the flow of patients across the system to reduce the pressure on our hospital services, which are at full capacity. This will include an emphasis on acute admissions, radiology services, long-stay patients (particularly older patients and patients needing rehabilitation and support on discharge) and hospital acquired conditions that extend people's length of stay and have a negative impact on health outcomes.

The commissioning of new facilities remains an essential element in our immediate and long-term sustainability. On completion of the Christchurch Hospital Hagley Building (ASB) in 2019, the DHB will undertake the significant migration of existing services into the new building and repatriation of outsourced services back into DHB facilities. This will be a sizable piece of work for our teams in 2019/20.

We also need to agree solutions to enable investment in the infrastructure needed to meet the growing and future demand for services. This will include a focus on completion of a number of master-plans and business cases over the coming year, such as the masterplan for the Christchurch Hospital campus.

In setting the DHB up for future success and creating a sustainable pathway forward, a population health and wellbeing approach is a critical factor in our strategy. This focus presents an opportunity for our community to work collaboratively to improve health outcomes. Cross-sector investment will be a key focus for the DHB in the coming year with a continued commitment to the Mana Ake initiative in schools and ACC partnerships to reduce harm and enhance recovery.

We will also continue to work closely with our primary care partners to support people closer to home and enable access to earlier intervention to improve health outcomes. This will include support for the rollout of new national primary mental health initiatives.

Equity is a key focus for our system and we will build on our partnerships with Māori and Pacific Whānau Ora agencies, to empower people to take the lead in their own health journey and provide people with access to the services they need earlier and closer to home. We plan to capture the lessons learnt in areas where equity gaps are closing in Canterbury and replicate this work across other areas.

We will progress the implementation of our People Strategy to support the health and wellbeing of our staff and create an environment where our people can thrive. Sick leave rates have been growing across the DHB highlighting the pressures on our workforce and the need for an increased focus on this work.

Continued implementation of our digital and IT transformation is also a critical success factor with value added technology supporting more efficient ways of working, reducing duplication and waste and improving decision making and planning with access to real-time serviced data.

The DHB is also committed to working closely with the Ministry of Health to agree a sustainable operating pathway and to understand and balance population need with fiscal responsibilities. Key fiscal challenges are not insignificant and a deliberate operational focus on service efficiency and effectiveness will help to support a sustainable future for our health system. Anticipated service changes are highlighted in the DHB's Annual Plan for 2019/20.

MEDIUM-TERM OUTLOOK

How are we going to get there?

3

Managing Our Business

This section highlights how we will organise and manage our business to support the realisation of our vision, enable the delivery of equitable, integrated and sustainable services and improve the health and wellbeing of our population.

3.1 Partnering for better outcomes

Our vision is based on bringing to life a truly integrated health system where everyone is working together to do the right thing for the patient and the system.

Working collaboratively has enabled us to respond to the changing needs of our population and is a critical factor in achieving our goals and objectives. The DHB's major strategic partnerships include:

Our District Alliance: The Canterbury Clinical Network (CCN) is where the DHB and its partner organisations come together to improve the delivery of health services and realise opportunities to improve health outcomes. This focus includes delivery of Canterbury's annual System Level Improvement Plan, which is incorporated into the DHB's Annual Plan.

Consumer Council: The DHB is committed to a culture that focuses on the patient and supports consumer participation in the design of services and strategies to improve health and wellbeing. This includes input into the work of our Alliance with consumers represented on work streams. The DHB also has a Consumer Council, where members ensure a strong and viable voice in health service planning and service redesign.

Clinical Partnerships: Clinical leadership is intrinsic to our success and a clinically-led management-enabled approach is embedded at all levels of our organisation, and across our local and regional alliances. The DHB also has a Clinical Board and Realign Alliance (across Christchurch Hospital campus) where members work together to influence the DHB's vision and play an important role in raising standards of patient care.

Public Health Partnerships: Our Community and Public Health (CPH) division takes the lead in the delivery of public health strategies and services to promote and protect the health and wellbeing of our population. CPH also serves as the Public Health Unit for South Canterbury and West Coast DHBs.

Collective public health focused initiatives include: Waha Toa Ora (Healthy Greater Christchurch), a DHB-led cross-sectoral partnership (based on the WHO Healthy Cities model), Healthy Christchurch, supporting community wellbeing including the 'All Right?' partnership with the Mental Health Foundation and the Greater Christchurch Partnership, supporting, a 'health in all policies' approach and the Community Workstream of the Urban Development Strategy. Our wellbeing focus is outlined in our Public Health Action Plan, which is incorporated into our Annual Plan.

3.2 Commitment to Māori

The values of our organisation, the way in which we work, and the manner in which we interact with others are all key factors in our success.

As a Crown agency, we recognise our responsibilities to uphold our obligations under the Te Tiriti o Waitangi. We work to improve the quality of care and equity of health outcomes for Māori and to address any systemic inequity, consistent with the recognised Tiriti principles of partnership, participation and protection.

The relationships and partnerships we build with our Māori stakeholders are fundamental to this work. We have a memorandum of understanding with Manawhenua Ki Waitaha, where we actively engage with Māori leaders in the planning and design of health services and strategies to improve Māori health outcomes. Members of the CCN Alliance's Māori Caucus and the Maui Collective (of Māori & Pacific Providers) bring a Māori perspective to the redesign of services and building of capacity across community services and support workforce development.

We also promote a culture that addresses inequitable health outcomes through open discussion, use of the Health Equity Assessment Tool (HEAT), universal performance targets and professional development and mentoring. In the coming year we will work with our partners to establish a clear collective strategy for improving Māori health outcomes in Canterbury.

3.3 Commitment to quality

The Canterbury DHB is committed to health excellence, with a strong focus on service quality and system performance using data and information to inform systematic improvement by teams and services. Working in partnership with patients and whānau is central to improved performance and we have made a commitment to using our inpatient experience survey results to improve the way we communicate with patients and their families.

The national Health Quality and Safety Commission (HQSC) Quality & Safety Markers supplement local performance framework and are reported to our governance groups to monitor patient safety and track the effectiveness of improvement activity. We report quarterly to our Clinical Governance Committee and the Board's Quality, Finance, Audit & Risk Committee. Performance against the Quality & Safety Markers is also reported publicly in our Annual Quality Accounts which can be found on our website.

The delivery of externally contracted services is aligned with national quality standards, and auditing of contracted providers includes quality audits. We also work with the other South Island DHBs, as a partner in the regional Quality & Safety Alliance, to implement quality and safety improvements.

3.4 Performance management

To support good governance, we have an outcome-based decision-making and accountability framework that enables our Board to monitor service performance and provide direction. We have also invested in the development of 'live data' systems where real-time operational information from within our hospitals enables responsive decision making and planning.

At the broadest level, we monitor health system performance against a core set of desired population outcomes, captured in our outcomes framework. The framework defines success from a population health perspective and is used as a means of evaluating the effectiveness of our investment decisions.

The DHB's service and financial performance is monitored through monthly and quarterly reporting to our Board and to the Ministry of Health against key financial and non-financial indicators aligned to the national performance framework. Our service performance is also audited annually against our Statement of Performance Expectations set out in section 4 of this document. The results are published in our Annual Report which can be found on our website.

3.5 Asset management

Having the right assets in the right places and managing them well is critical to the ongoing provision of high-quality and cost-effective health services.

As at 30 June 2019 the DHB's forecast asset value is $756M (book value). As an owner of Crown assets, we are accountable to the Government for the financial and operational management of those assets.

Since the earthquakes, our capital intentions have been updated to reflect known changes in our asset state and future intentions, in line with our earthquake repair programme and Christchurch Hospital campus redevelopments. In doing so, the DHB has developed and implemented an Asset Management Policy and Asset Management Strategy and a five-year Asset Management Maturity Improvement Plan.

In response to Treasury requirements for monitoring investments across government, the DHB is also redeveloping its Long-term Investment Plan with a ten-year outlook. This Plan reflects the anticipated impact of changing patterns of demand and new models of care on our future asset requirements and will support investment decisions going forward.

Refer to Section 4 for a summary of the DHB's major capital investments to 2023.

3.6 Risk management

The DHB manages and monitors risk to ensure we are meeting our obligations as a Crown Entity. Our risk management processes are aligned to the main elements of the International Standard for Risk Management AS/NZS ISO 31000:2009.

We also maintain Divisional Risk Registers, identifying and providing assurance on the management of the most significant risks faced by the DHB. The top tier risks are reviewed by the Executive Management Team and the DHB Board's Quality, Financial, Audit & Risk Committee every two months, and the full Risk Register is reviewed twice a year by our Board.

3.7 Ownership interests

The Canterbury DHB has a number of ownership interests that support the delivery of health services including two operational subsidiaries, both of which are wholly owned by the DHB.

Canterbury Linen Services Limited: provides laundry services to DHB hospitals and external commercial clients. The Canterbury DHB owns all shares, as well as the land and buildings.

Brackenridge Estate Limited: provides residential care, respite services and day programmes for people with intellectual disability and high dependency needs. The primary source of funding is service contracts with the Ministry of Health. The DHB is the sole shareholder.

The South Island Shared Service Agency Limited: functions as the South Island Alliance Programme Office. It is jointly owned and funded by the five South Island DHBs and provides audit services and supports regional service development on our behalf.

The New Zealand Health Partnership Limited: is owned and funded by all 20 DHBs and aims to enable DHBs to collectively maximise and benefit from shared service opportunities. Canterbury participates in the Finance, Procurement and Supply Chain programme.

The New Zealand Health Innovation Hub: is a joint partnership between Canterbury, Counties Manukau, Waitemata and Auckland DHBs. The Innovation Hub engages with clinicians and industry to develop, validate and commercialise health technologies and improvement initiatives that will deliver health and economic benefits to the system.

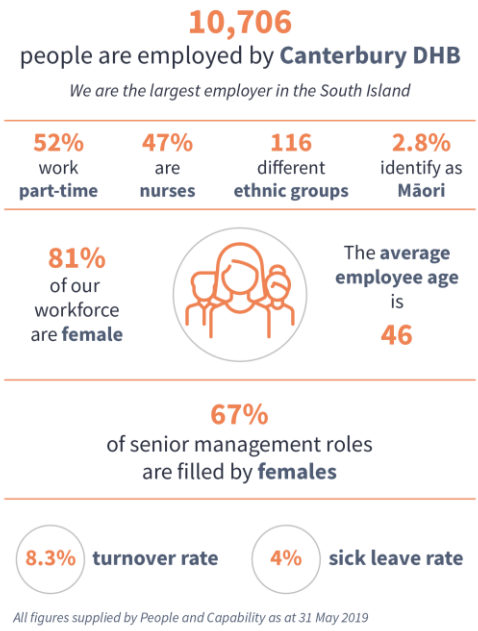
The DHB has plans to enter into two further agreements in the coming year:

HealthPathways: is an online tool providing clinical and process guidance for patient management. The content is owned by the Canterbury DHB with the software and process owned by Streamliners Ltd. The parties are proposing to enter into a cross-licensing agreement and establish a Charitable Trust with the primary purpose of funding the ongoing development of HealthPathways locally. The DHB will be seeking Ministerial consent for the proposal.

HealthOne: is a shared data repository jointly developed by the DHB and Pegasus Health. There is the prospect of licensing HealthOne to other NZ health providers and the parties propose to enter into a Limited Partnership to formalise the relationship and support this work. The DHB will also seek Ministerial consent for this proposal.

Building our capability

3.8 Investing in our people



Many of our people are still facing challenges, both at home and at work. The earthquakes have driven increased demand and health need, and we are still working through our repair and redevelopment programme which is disruptive and stressful.

The DHB is committed to being a good employer. We promote equity, fairness, a safe and healthy workplace, and have a clear set of organisational values and core operational policies. These include a Code of Conduct, Equality, Diversity and Inclusion Policy and a Wellbeing Policy. The DHB will also implement the national Care Capacity Demand Management agreement by June 2021.

We are reviewing our people processes and systems and engaging in conversations about how we can put our people at the heart of all that we do. There is a strong commitment to making things better. The DHB has adopted a People Strategy to ensure actions which will positively support the wellbeing of our people.

A range of initiatives will be developed and rolled out to deliver on the priorities in our People Strategy and in doing so we will create a culture where:

- Everyone understands their contribution
- Everyone can get stuff done
- Everyone is empowered to make it better
- Everyone is enabled to lead
- Everyone is supported to thrive.

Future Health Workforce: Alongside our People Strategy, we identify available talent and expand workforce capability and support the training and education of our future workforce through: participation in the regional Workforce Development Hub; links with the education sector; sharing training resources; and support for internships and clinical placements in our hospitals.

Utilising our Dedicated Education Units, there is a well-developed pipeline of nursing students trained within the Canterbury health system, with over 900 nursing student placements each year. This student cohort feeds into the Canterbury Nursing Entry to Practice (NetP) Programme and New Entry to Specialty Practice Mental Health & Addiction Programme that successfully employs over 260 new registered nurses annually.

The DHB is currently working on a long term nursing workforce development plan, examining: future nursing roles and pathways for advancing nurses to ensure people are working at top of scope. To ensure a consistent approach across our health system, and across the South Island, we will work with regional nursing leaders to explore opportunities to establish a standardised approach to professional development for Nurse Practitioners. This will involve identifying current processes and models to ensure nurse practitioner professional development is well supported, with a view to agreeing a regional approach to investment across the South Island.

The DHB is also working on the development of an Allied Health Strategy to support the re-orientation of allied health, with a stronger focus on wellbeing, prevention, early intervention and enablement. The strategy will examine future allied health roles, looking at build capability and expanding the skill mix, experience and diversity of our allied health workforce. This will include regional work to build talent pipelines and identify a wider recruitment pool to support a workforce more representative of our population.

In addition, the DHB remains fully committed to providing a high standard of education and training for our Resident Medical Officers (RMOs) and meeting all our obligations and requirements for prevocational and vocational training in accordance with the Medical Council of New Zealand and Vocational Specialist Colleges. This is evidenced by the establishment and ongoing support of clinical governance and operational structures and processes, such as the Medical Education and Training Unit, to support education and training for RMOs across the DHB.

Māori Health Workforce: The DHB has made an overarching commitment to encourage greater participation of Māori in the health workforce. Employee ethnicity data shows Māori make up 9.2% of our population but just 2.8% of the DHB workforce. [1]

[1] This figure is likely to be understated. In April 2019, 18% of staff had no ethnicity declared, of those who did 3.4% identified as Māori.

In support of this direction we participate in the national Kia Ora Hauora programme, aimed at increasing the number of Māori working in health, by supporting pathways into tertiary education, local health scholarships and work placements.

We have established a blended model for a NetP Māori Initiative titled 'Korimako', in partnership with Pegasus Health and the Maui Collective (of Māori & Pacific Providers). This includes annual funding for new graduate registered nurse positions as a sustainable pathway for building a primary care registered Māori nursing workforce.

The DHB is also working with the West Coast DHB to review recruitment practices, particularly those that might unintentionally limit job placement prospects for Māori and Pacific applicants. With 18% of staff having no ethnicity recorded, we are engaging with staff to improve the collection and recording of ethnicity data to improve workforce planning.

Other areas of workforce development and investment for the period of this Plan are highlighted in the DHB's Annual Plan for 2019/20.

3.9 Investing in information systems

Connecting up health information services is central to the DHB's vision and, by realising opportunities to reduce waste and duplication, is a key factor in the future sustainability of our health system.

National, regional and local engagement has led the DHB's Information Service Group to identify eight strategic areas of focus as a means of supporting the delivery of health services:

- Digital transformation
- Projects supporting facilities redevelopment
- Capabilities maintenance
- ISG support for our people and the DHBs we serve
- Developing our team dynamic
- Operations maintenance
- Security and assurance compliance
- Disaster recovery.

In support of this work, the DHB is taking a lead in rolling out information solutions that transform the way health professionals across the South Island make requests, send referrals and share patient information, such as: HealthOne; Health Connect South; and the South Island Patient Information Care System (SI PICS). Our transalpine partnership with the West Coast DHB also makes shared information important, with a focus on aligning IT systems to facilitate staff working across both DHBs. A combined transalpine service desk will be implemented in 2019/20.

Areas of investment for the period of this Plan include:

Telehealth, videoconferencing and mobile technology that support staff working remotely are an important factor in improving service capacity and equity of access for patients and their families. This includes scoping a proposal for lone worker duress for community workers, commencing updates for our end user mobile device management and implementing Microsoft G2018 licenses for Teams, Exchange Online and Office 365.

We will continue to connect up services and systems electronically with the digitalisation of our new hospital which includes the development of a business case for a mobility suite, exploring the viability of a staff on call/duty application and implementing Cortex for nine services in 2019/20.

We are also reviewing and enhancing our infrastructure to ensure the reliability of clinical and business systems and to comply with approved standards and architecture. This includes continued implementation of national expectations around a move to Cloud technology and adoption of national systems, to improve patient safety and the quality of services we deliver.

Supporting the national bowel screening programme: As one of four national providers of ProVation MD (gastroenterology procedure documentation software), the DHB is working with the National Bowel Screening Programme to improve information flow. Vendor agreements are expected to be in place by Q1 2019/20. We will then work with the vendor to develop an implementation plan to support the rollout of the Screening Programme which will support improved detection and management of bowel cancer.

Moving to Cloud technology: Canterbury DHB is planning to move to a hybrid Cloud technology to achieve operational capability improvements including disaster recovery. By Q3 2019/20 the DHB will have established a Cloud business office which will support the processes, technology and people capability required to run the hybrid Cloud environment. We will then establish a migration plan in Q3. As part of this programme of work the DHB will continue to improve our cyber security, aligned to NZ Cyber security goals. We expect this work to be completed by Q4.

The DHB will report quarterly to the Ministry of Health (Data and Digital) on the DHB's ICT investment to support collective decision making and maximise the value of sector investment.

3.10 Investing in facilities

In the same way that workforce and information technology underpin and enable our transformation, health facilities can both support and hamper the quality of the care we provide.

The Canterbury DHB is in the midst of a significant redevelopment and repair programme, impacting on almost every facility we own. Completion of the Hagley Building (Acute Services) on the Christchurch Hospital site (along with the newly completed Outpatients

facility) will allow us to regain some of the capacity lost after the earthquakes. These fit-for-purpose facilities will also allow us to make efficiency savings by co-locating and consolidating services and supporting more responsive and integrated service models.

Delays with the building programme have meant the DHB has been operating with significantly reduced capacity and has been unable to realise anticipated efficiency gains for the past several years. Increased construction and fixtures and fitting costs are also creating significant pressure. It is critical that the Hagley Building is completed without further delay.

Our growing population and increasing service demands also mean solutions need to be found to increase our capacity beyond what will be restored once the redevelopment is complete. A number of business cases and masterplans are underway.

Areas of investment for the period of this Plan include:

Christchurch Hospital Energy Centre: The Boiler House servicing the Christchurch Hospital campus and Canterbury Health Laboratories is seismically compromised. The design of a new Energy Centre to replace the Boiler House, is underway, with completion anticipated by early/mid 2021.

The Princess Margaret Hospital: The detailed business case for the relocation of specialist mental health services from The Princess Margaret Hospital to the Hillmorton Hospital campus has been approved, with an estimated capital cost of $79m (funded by crown capital funding). The project is being managed by the DHB and planning and design has commenced. At this stage we anticipate relocation will be complete in 2023.

Hillmorton Hospital: Longer-term master-planning is also underway to determine the future use of other existing buildings and facilities on the Hillmorton Hospital campus including Adult Acute Services. The masterplan is expected to be complete in 2019/20.

Christchurch Hospital: In late 2018, as part of the indicative prioritisation of DHB capital projects the Ministry of Health advised that the Christchurch Hospital Campus Redevelopment (Parkside) had been prioritised for investment. Work is progressing with long-term master-planning for the campus, with the Masterplan and Indicative Business Case for Parkside and new tower developments expected to be complete by mid-2019. With approval, the DHB will progress development of a detailed business case.

Canterbury Health Laboratories: An initial strategic assessment was submitted in regards to a future facility for Canterbury's laboratory services. This will now be included in a wider programme business case to consider and determine the optimal phasing of future investments, including a future Cancer Centre.

Over the coming year the DHB will continue to progress with upgrading and repairing the remaining earthquake damaged buildings and will also consider the future use of all of its rural hospital facilities.

3.11 Cross-sector investment

Recognising the wider influences that shape the health and wellbeing of our population, the DHB works in partnership with organisations from outside the health sector to improve health outcomes for our population.

Earthquake recovery and the mosque attacks are an important focus of our cross-sectoral work. This involves support and advice into policy processes, community resilience initiatives, and psycho-social recovery—all of which contribute to our vision of a healthier Canterbury.

We are also working closely with ACC, Corrections and the Ministries of Social Development, Education and Justice, investing in a number of initiatives aimed at improving health outcomes for the most vulnerable in our community.

Areas of investment for the period of this Plan include:

Mana Ake: Stronger for Tomorrow: The DHB is taking the lead in implementing this significant initiative, working through the CCN alliance with the Ministry of Education to develop a wellbeing support system for children, their families/whānau and teachers.

Wellbeing and Resilience Response: The DHB is working closely with other agencies and organisations to provide a locally-led and integrated response to the March 2019 mosque attacks and to ensure people get the help they need when they need it. This work includes the development of an online Resilience Hub, a central point for health and wellbeing support with links to housing, welfare, education etc.

Canterbury Children's Team: The DHB will continue to work in a collaborative partnership with Oranga Tamariki as they transition to a new model, to ensure support for children and young people in Canterbury.

The Integrated Safety Response Pilot: The DHB participates in this Police-led social investment strategy to pilot rapid responses from government and social agencies to better meet the needs of people affected by family violence.

DHB/Police Watch-house Nurse Initiative: The DHB will continue to support this initiative where our nurses work 24/7 alongside police custody staff in the police watch-house to assess people in custody for mental health, alcohol and other drug issues and help to reduce their risks to themselves and others.

The All Right? Social Marketing Campaign: The DHB will continue to work in partnership with the Mental Health Foundation to support people's mental health and wellbeing after the earthquakes.

Pasifika Futures: The DHB is working in partnership with the Whānau Ora Commissioning Agency to build the capability and capacity of Pacific families. This includes support for the Etu Pasifika healthcare clinic.

Te Putahitanga: The DHB will also seek to develop a closer partnership with the Whānau Ora Commissioning Agency, Te Putahitanga, to enable whānau-centered support for Māori living with long-term conditions.

Step Up: The DHB is working alongside the Ministry of Social Development and Pegasus Health to implement a new prototype primary care service to support people with health conditions back into employment.

Pathway for Offenders: The DHB is working in partnership with the Department of Corrections to improve links with primary care to support the health and wellbeing of people on release from a corrections facility or deported from Australia.

Strength and Balance Programmes: The DHB is partnering with ACC to enhance our Falls Prevention Programme by providing increased access to community-based programmes designed to reduce harm from falls, particularly for our older population.

Spinal Cord Impairment Initiative: The DHB is partnering with Counties Manukau and ACC to support improved outcomes for people with spinal cord injuries. Canterbury is one of two spinal centres in the country and provides treatment for patients from the middle of the North Island (Turangi) to the bottom of the South including Stewart Island and the Chathams.

Non-Acute Rehabilitation Pathways: The DHB is also partnering with ACC to better meet the needs of people with injuries and improve long-term outcomes, by adopting a more restorative approach to recovery.

Monitoring Our Performance

3.12 Improving health outcomes

As part of our accountability to our community and Government, we need to demonstrate whether we are succeeding in achieving our objectives and improving the health and wellbeing of our population.

DHBs have a number of different roles and associated responsibilities. In our governance role, we are concerned with health equity and outcomes for our population and the sustainability of our health system. As a funder, we are concerned with the effectiveness of our health system and the return on our investment. As an owner and provider of services, we are focused on the quality of the care we deliver, the efficiency with which it is delivered, and the safety and wellbeing of the people who work for us.

There is no single performance measure or indicator that can easily reflect the impact of the work we do and we cannot measure everything that matters for everyone. In line with our vision for the future of our health system, we have developed an over-arching intervention logic and system outcomes framework.

The framework helps to illustrate our population health-based approach to performance improvement, by highlighting the difference we want to make in terms of the health and wellbeing of our population. It also encompasses national direction and expectations, through the inclusion of national targets and system level performance measures.

At the highest level the framework reflects our three strategic objectives and identified three wellbeing goals, where we believe our success will have a positive impact on the health of our population.

Aligned to each wellbeing goal we have identified a number of population health indicators which will provide insight into how well our system is performing over time. The nature of population health is such that it may take a number of years to see marked improvements. Our focus is to develop and maintain positive trends over time, rather than achieving fixed annual targets.

MAIN MEASURES OF PERFORMANCE

To evaluate our performance over the shorter-term, we have identified a secondary set of contributory measures, where our performance will impact on the outcomes we are seeking. Because change will be evident over a shorter period of time, these contributory measures have been selected as our main measures of performance.

We have set performance standards for these measures in order to evaluate our performance and determine if we are moving in the right direction. Tracking our performance in this way helps us to evaluate our success in areas that are important to our community and stakeholders and is an essential part of the way in which we hold ourselves to account.

These contributory measures sit alongside our annual Statement of Performance Expectations, outlining the service we plan to deliver and the standards we expect to meet in the coming year. They are also reflected in our System Level Measures Improvement Plan, where we collaborate with our partner organisations to improve health outcomes for our population.

The intervention logic diagram on the following page demonstrates the anticipated value chain, by illustrating how the services we fund or provide will impact on the health of our population. The diagram also demonstrates how our work contributes to the goals of the wider South Island region and delivers on the expectations of Government.

Our year-end service performance results are reported to our community in our Annual Report, alongside our year-end financial results. The DHB's Annual Reports can be found on our website www.cdhb.health.nz

Our Statement of Performance Expectations for 2019/20 can be found in the Annual Operating Intentions section of this document (Section 4).

As a Crown entity, responsible for Crown assets, the DHB also provides regular financial and non-financial performance reporting to the Ministry of Health. The DHB's obligations under the Ministry's monitoring framework are highlighted in the DHB's Annual Plan.

Overarching Intervention Logic

Te Tiriti O Waitangi

We agree that the Treaty of Waitangi establishes the unique & special relationship between Iwi, Māori & the Crown. Parties with Treaty obligations will honour these when participating in Alliance activities.

Wellbeing Outcomes

3.13 People are healthier and able to take greater responsibility for their own health

WHY IS THIS A PRIORITY?

New Zealand is experiencing a growing prevalence of long-term conditions. Cancers, heart disease, musculoskeletal conditions, respiratory disease, diabetes and mental illness are major drivers of poor health and premature mortality and account for significant pressure on our health services. The likelihood of developing a long-term condition increases with age and as our population ages the demand for health services will continue to grow. The World Health Organisation (WHO) estimates that long-term conditions make up 87.3% of all health loss in New Zealand up from 82.5% in 1990.[2]

Tobacco smoking, inactivity, poor nutrition and hazardous drinking and substance abuse are major risk factors for a number of the most common long-term conditions. These are modifiable risk factors and can be reduced through supportive environments and improved awareness, which enable people to take personal responsibility for health and wellbeing. Public health, promotion and education services, by supporting people to make healthier lifestyle choices, will improve health outcomes for our population. Because these major risk factors also have strong socio-economic gradients, a change in behaviours will contribute to reducing inequities in health outcomes between population groups.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

A REDUCTION IN SMOKING RATES

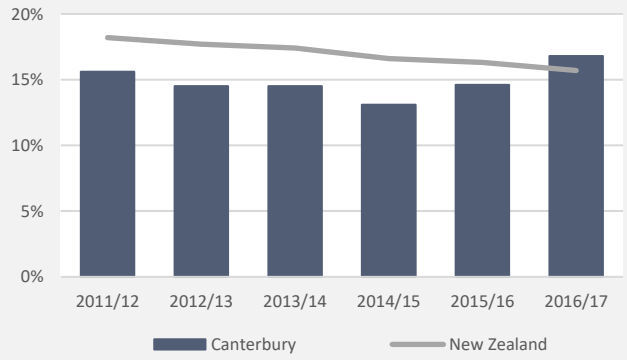
Smoking and exposure to second-hand smoke causes an estimated 4,627 premature deaths in New Zealand every year. Tobacco smoking is a major risk factor for many preventable illnesses and long-term conditions, including cancer, respiratory disease, heart disease and stroke.

In addition, tobacco and poverty are inextricably linked. In some communities, a sizeable portion of household income is spent on tobacco, meaning less money for necessities such as nutrition, education and health.

Supporting people to say 'no' to smoking is our foremost opportunity to improve health outcomes and to reduce inequalities in health status between population groups.

Data source: National NZ Health Survey[3]

Measure: Proportion of the population (15+) who smoke



A REDUCTION IN OBESITY RATES

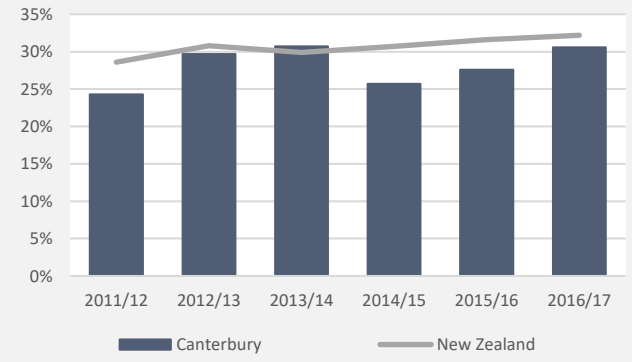
There has been a steady rise in obesity rates in New Zealand across all ages, genders and ethnicities. Obesity is set to overtake tobacco as the leading risk to health and the most recent NZ Health Survey found 32% of all adults and 12% of children were obese.

Not only does obesity impact on the quality of people's lives, but it is a significant risk factor for many of the leading long-term conditions in Canterbury including heart disease, respiratory disease, diabetes and stroke.

Supporting people to achieve a healthier body weight is fundamental to improving people's wellbeing and to preventing poor health and disability at all ages.

Data source: National NZ Health Survey[4]

Measure: Proportion of the population (15+) who are obese



[2] Ministry of Health, Health and Independence Report 2017

[3] The NZ Health Survey, commissioned by the Ministry of Health, collects information about the health and wellbeing of New Zealanders, the services they use and key factors that affect their health. Every year about 14,000 households take part in the survey with total population results presented annually and ethnicity breakdowns presented over combined time periods (due to small population numbers). Smoking rates, by ethnicity, over the combined period 2014-2017 reflect, 14.8% of the total Canterbury population identified as current smokers, compared to 39.9% of Māori and 36.5% of our Pacific population.

[4] The NZ Health Survey defines 'Obese' as having a Body Mass Index (BMI) of >30 or >32 for Māori and Pacific populations. Rates are available by ethnicity over the combined period 2014-2017 reflect 28% of the total population identified as obese, compared to 46.3% of Māori and 58.7% of Pacific.

FEWER AVOIDABLE HOSPITAL ADMISSIONS

A number of admissions to hospital are for conditions which are seen as preventable through lifestyle change, a reduction in risk factors and earlier intervention by primary and community services.

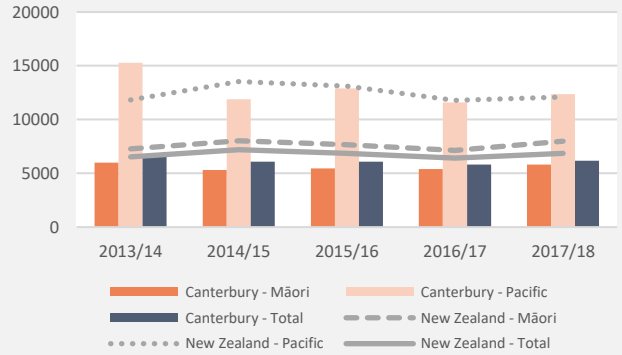
Ensuring children have the best start to life is a crucial component in the long-term health and wellbeing of our population and keeping children out of hospital is a priority. A reduction in preventable admissions will also free up hospital and specialist resources and reduce pressure on our health system.

This measure is seen as an indicator of the accessibility and effectiveness of health care and a marker of increased integration between health and social services. Disparities are evident for Pacific children and closing this gap is a focus for the DHB.

Data source: Ministry of Health DHB Performance Reporting [5]

Measure: Rate of ambulatory sensitive hospital admission for children (0-4)

Base	Target			
17/18	19/20	20/21	21/22	22/23
6,184	<6,871	<6,871	<6,871	<6,871



CHILDREN HAVE IMPROVED ORAL HEALTH

Poor oral health is a marker for a range of poor health outcomes in childhood and later in life. There is a direct link between good nutrition and good oral health, and good nutrition is also an important factor in supporting a healthy weight and reducing obesity.

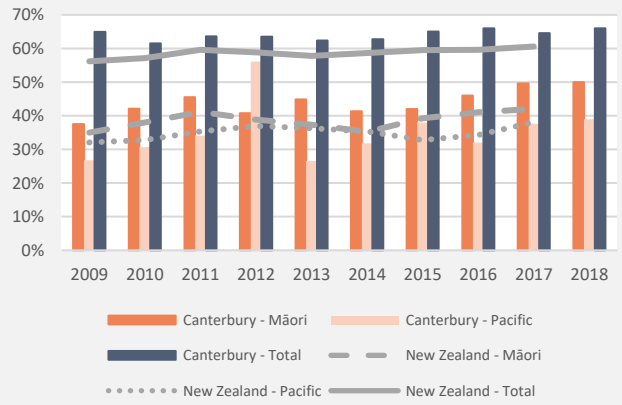
Rates of early childhood caries (holes or fillings) are high in Canterbury, with significant disparities. Reducing this disparity provides a significant opportunity to improve long-term health outcomes for Māori and Pacific children.

Improvements in the proportion of children caries-free at age five is seen as a proxy indicator of the effectiveness of mainstream services in reaching those most at risk. It is also an indicator of improved nutrition and wellbeing.

Data source: School & Community Oral Health Services and Statistics New Zealand Population Projections [6]

Measure: Children caries free at age five

Base	Target			
2018	2019	2020	2021	2022
66%	>67%	>67%	>67%	>67%



FEWER YOUNG PEOPLE TAKE UP SMOKING

The highest prevalence of smoking is amongst younger people, and preventing young people from taking up smoking is a key contributor to reducing smoking rates across our total population.

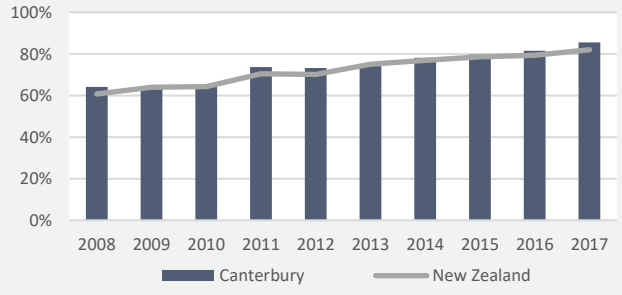
Because Māori and Pacific people have higher smoking rates, reducing the uptake amongst Māori and Pacific youth provides a significant opportunity to improve long-term health outcomes for these population groups and reduce inequalities.

A reduction in the uptake of smoking by young people is seen as a proxy indicator of the success of our health promotion activity and a change in the social and environmental factors that support healthier lifestyles.

Data source: National ASH Year 10 Survey [7]

Measure: 'Never smokers' amongst Year 10 students

Base	Target			
2018	2019	2020	2021	2022
n.a	>82%	>82%	>82%	>82%



[5] This measure is a national System Level Measure and refers to hospitalisations for conditions considered preventable including: asthma, vaccine-preventable diseases, dental conditions and gastroenteritis. The DHB's aim is to maintain performance below the national rate (reflecting fewer people presenting to hospital) and to reduce equity gaps between populations. The measure is a non-standardised rate per 100,000 people and results differ to those previously presented, reflecting updated national data provided by the Ministry to June 2018

[6] This measure is a national DHB performance indicator (CW01) and is reported annually for the school year. Ethnicity results are calculated by undertaking a data match between the Oral Health Service Patient Management System (Titanium) and Canterbury Primary Care Enrolment data.

[7] The ASH Survey is an annual survey of around 30,000 Year 10 students across New Zealand. Run by Action on Smoking & Health the survey provides valuable insights into tobacco use trends amongst young people. The 2018 results were not available at the time of printing. For more detail see www.ash.org.nz.

3.14 People stay well in their own homes and communities

WHY IS THIS A PRIORITY?

When people are supported to stay well, and can access the care they need closer to home, in the community, they are less likely to experience acute illness or the kind of complications that might lead to a hospital admission, residential care or premature mortality (death). This is not only better in terms of people's health outcomes and quality of life, but it reduces the pressure on our hospitals and frees up health resources. Studies show countries with strong primary and community care systems have lower rates of premature death from heart disease, cancer and stroke. They also achieve these health outcomes at a lower cost than countries with systems that focus more heavily on a specialist or hospital level response.

Health services also play an important role in supporting people to regain functionality after illness and supporting people to remain independent for longer. Even where returning to full health is not possible, access to responsive, needs-based rehabilitation, pain management and palliative care services can help to improve the quality of people's lives.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

A REDUCTION IN ACUTE HOSPITAL ADMISSIONS

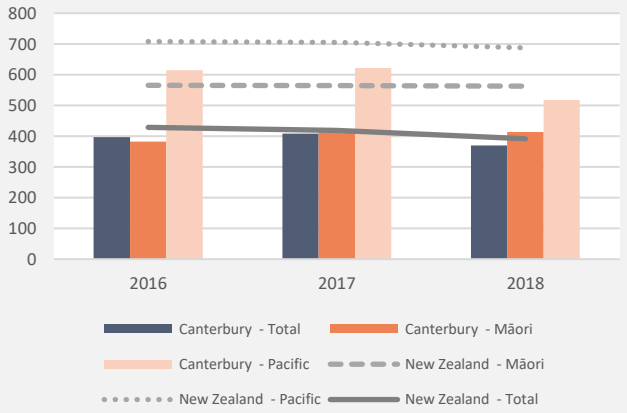
Acute (unplanned) hospital admissions account for almost two thirds of hospital admissions in New Zealand.

Acute hospital bed-days are used as a proxy indicator of improved long-term conditions management and access to timely and appropriate treatments that reduce crisis and deterioration. The measure also reflects the quality and effectiveness discharge planning.

Reducing acute hospital admissions and the length of time people spend in our hospitals has a positive effect on people's health. It also enables more efficient use of specialist resources that would otherwise be captured responding to demands for urgent care, allowing the DHB to provide more planned care.

Data Source: National Minimum Data Set[8]

Measure: rate of acute hospital bed-days (age standardised, per 1,000 people)



MORE PEOPLE LIVING IN THEIR OWN HOME

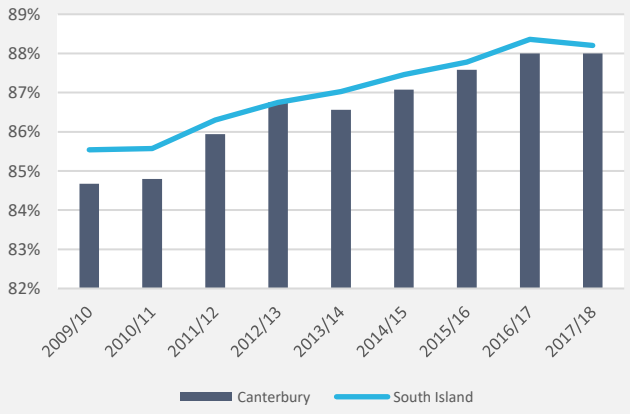
While living in residential care is appropriate for a small proportion of our population, studies have shown a higher level of satisfaction and better long-term outcomes when people remain in their own homes and are positively connected to their local communities.

Living in residential care is also a more expensive option and resources could be better spent providing home-based support and packages of care to help people stay well in their own homes.

An increase in the proportion of older people living in their own homes is seen as a proxy indicator of how well the health system is enabling people's wishes to remain in their own homes, managing age-related and long-term conditions and responding to the needs of our older population groups.

Data source: SIAPO Client Claims Payment System

Measure: Proportion of the population (75+) living in their own home



[8]This is a national System Level Measures a data is provided by the Ministry of Health via the national minimum data set. This is a newly introduced measure with only a three-year time period currently available for comparison, a longer-term view will build over time.

PEOPLE'S CONDITIONS ARE DIAGNOSED EARLIER

People want certainty regarding access to health services when they need it, without long waits for diagnosis or treatment.

Timely access to diagnostics, by improving clinical decision-making, enables earlier and more appropriate intervention and treatment. This contributes to both improved quality of care and improved health outcomes.

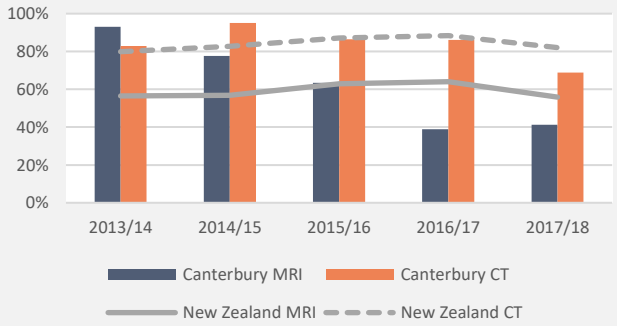
Wait times for diagnostics can therefore be seen as a proxy indicator of the responsiveness of our health system and our ability to match capacity with demand, particularly when we are seeking to minimise wait times and operating within a constrained environment.

Capacity is stretched in Canterbury and we are working hard to find solutions in order to improve results.

Data source: DHB Patient Management System[9]

Measure: People receiving their non-urgent MRI or CT scan within six weeks

	Base	Target			
	17/18	18/19	19/20	20/21	21/22
MRI	41%	90%	90%	90%	90%
CT	69%	95%	95%	95%	95%



FEWER AVOIDABLE HOSPITAL ADMISSIONS

An increasing number of admissions to hospital are for conditions which are seen as preventable through lifestyle change, risk factor reduction, earlier intervention and the effective management of long-term conditions.

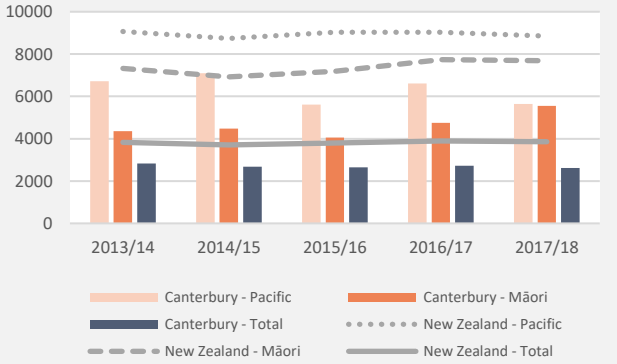
With the right approach, people can live healthier lives and minimise the deterioration of their condition that leads to acute illness or hospital admission. Disparities are evident and addressing the gap provides a significant opportunity to improve long-term health outcomes for Māori and Pacific. A reduction in avoidable admissions will also reduce pressure on our hospital resources.

A key factor in reducing avoidable hospital admissions is improved coordination between primary and secondary services. As such, this measure is seen as an indicator of the accessibility and effectiveness of primary care and a marker of a more integrated health system.

Data source: Ministry of Health Performance Reporting [10]

Measure: Rate of ambulatory sensitive hospital admission for adults (45-64)

Base	Target			
17/18	19/20	20/21	21/22	22/23
2,623	<2,596	<2,596	<2,596	<2,596



FEWER FALLS-RELATED HOSPITAL ADMISSIONS

Compared to older people who do not fall, those who fall experience prolonged hospital stays, loss of confidence and independence and an increased risk of institutional care.

With an ageing population, our focus on reducing harm from falls will help people to stay well and independent and reduce the demand for hospital and residential services.

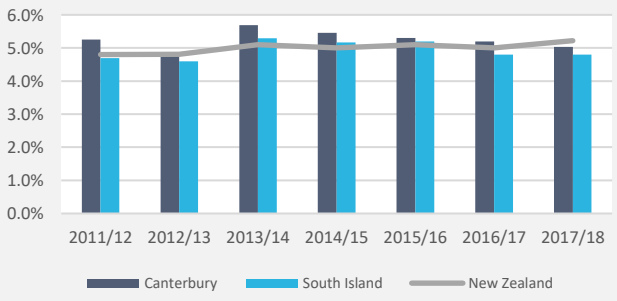
Solutions to preventing falls include appropriate medications use, improved physical activity and nutrition, access to restorative support and rehabilitation and a reduction in personal and environmental hazards.

This measure is seen as an indicator of the responsiveness of our system to the needs of our older population, as well as a measure of the quality of the services being provided.

Data source: National Minimum Data Set [11]

Measure: Population (75+) admitted to hospital as a result of a fall

Base	Target			
17/18	19/20	20/21	21/22	22/23
5.0%	<5.5%	<5.5%	<5.5%	<5.5%



[9] The radiology measures are national DHB performance indicators. Baselines differ to previously printed results, having been reset from year-end (June of each year) to full year (12 month) results.

[10] This measure is a national DHB performance indicator and refers to hospitalisations for conditions considered preventable including: asthma, vaccine-preventable diseases, dental conditions and gastroenteritis. The aim is to maintain performance below the national rate (reflecting fewer people presenting to hospital) and reduce equity gaps between populations. The measure is a standardised rate per 100,000 people and results differ to those previously presented, reflecting updated national data provided by the Ministry of Health to June 2018.

[11] The target for this measure has been set with the aim of maintaining rates in line with national performance, but allowing for an anticipated increase in falls related to our ageing population.

3.15 People with complex illness have improved health outcomes

WHY IS THIS A PRIORITY?

For people who do need a higher level of intervention, timely access to high quality specialist care and treatment is crucial in delivering a positive outcome, supporting recovery or slowing the progression of illness. Improved access and shorter wait times are seen as indicative of a well-functioning and sustainable system, able to match capacity to demand and managing the flow of patients to ensure people receive the service they need when they need it.

As the primary provider of hospital and specialist services in Canterbury, this goal also considers the effectiveness and the quality of the treatment we provide. Adverse events, ineffective treatment or unnecessary waits can cause harm and result in longer hospital stays and complications that have a negative impact on the health of our population, people's experience of care and their confidence in the health system. Ineffective or poor-quality treatment and long waits for treatment also waste resources and add unnecessary cost.

We are in the midst of a significant facilities redevelopment and repair programme and we are transforming the way we deliver services to increase capacity with the resources we have available. We are focusing on improving the flow of patients across our system and reducing duplication of effort to maintain service access while reducing waiting times for treatment. We also aim to increase the value from our investment in technology to support clinical decision making and improve the quality of the care we provide.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

A REDUCTION IN AMENABLE MORTALITY

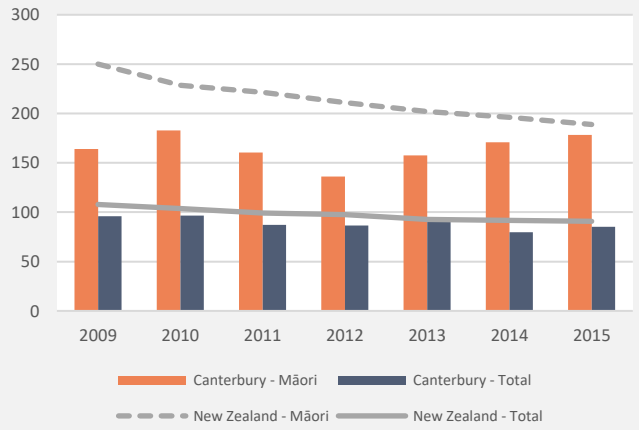
Amenable mortality is defined as premature death (before age 75) from conditions that could have been avoided through lifestyle change, earlier intervention, or more effective management of long-term conditions.

There are many economic, environmental and behavioural factors that have an influence on people's life expectancy. However, timely diagnosis, improved management of long-term conditions and access to safe and effective treatment are crucial factors in improving survival rates for most complex illnesses, such as cancer, diabetes and heart disease.

A reduction in the rate of amenable mortality can be used to reflect the responsiveness of the health system to the needs of people with complex illness, and as an indicator of access to timely and effective care.

Data Source: National Mortality Collection[12]

Measure: rate of amenable mortality for people aged under 75 (age standardised, per 100,000 people)



A REDUCTION IN ACUTE READMISSIONS

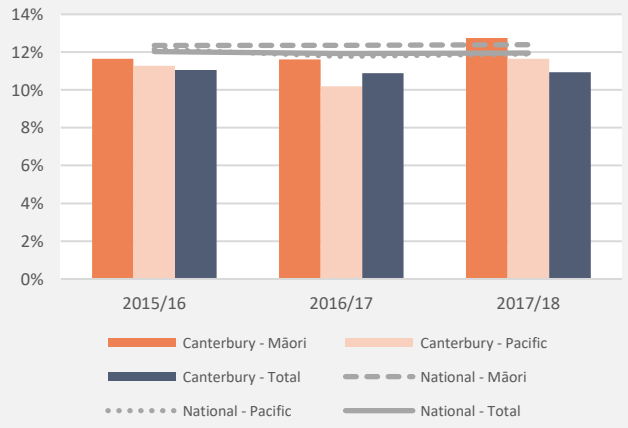
As well as reducing public confidence and driving unnecessary costs, patients who are readmitted to hospital are more likely to experience negative longer-term outcomes.

Key factors in reducing acute readmissions include patient safety and quality standards, discharge planning and care coordination at the interface between services. Ensuring people receive effective treatment in our hospitals and appropriate support and care on discharge.

Readmission rates are therefore a useful marker of the quality of care being provided, and the integration between service providers. These rates are also a good balancing-measure to productivity measures such as reductions in lengths of stay.

Data source: Ministry of Health Performance Reporting [13]

Measure: Rate of acute readmissions to hospital within 28 days of discharge (standardised) per 100,000 people



[12] Performance data for this measure is sourced from the national mortality collection which is three years in arrears. The 2015 results are provisional

[13] This data is provided by the Ministry of Health and sourced from the National Minimum Data Set. Data is provided three months in arrears, with results being the year to March 2018. This measure has a new national definition and a longer-term view will build over time.

SHORTER WAITS FOR URGENT CARE

Emergency Departments (EDs) are often seen as a barometer of the effectiveness, efficiency and responsiveness of the hospital and wider health system.

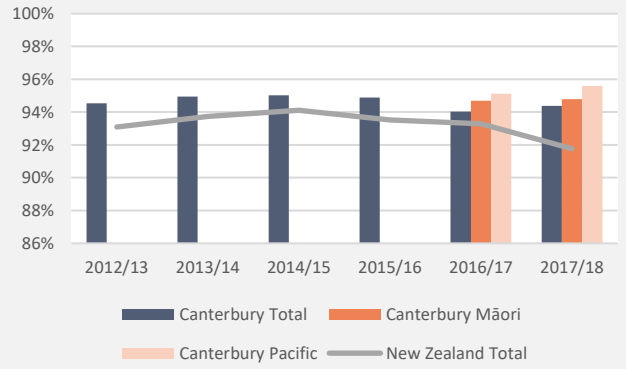
Long waits in ED are linked to overcrowding, poor patient experience, longer hospital stays and negative outcomes for patients. Enhanced performance will not only contribute to improved patient outcomes, by enabling early intervention and treatment, but will improve public confidence and trust in our health services.

Solutions to reducing ED wait times address the underlying causes of delay and span not only hospital services but the wider health system, ensuring that only those who require emergency services present to ED. In this sense, this indicator is a marker of the responsiveness of our whole system to the urgent care needs of our population.

Data source: DHB Patient Management System [14]

Measure: People admitted, discharged or transferred from ED within 6 hours

Base	Target			
17/18	19/20	20/21	21/22	22/23
94%	95%	95%	95%	95%



SHORTER WAITS FOR PLANNED CARE

Access to elective services (including specialist assessment, treatment and surgery) improves the quality of people's lives by removing pain or discomfort, slowing the progression of disease and helping to restore independence and wellbeing.

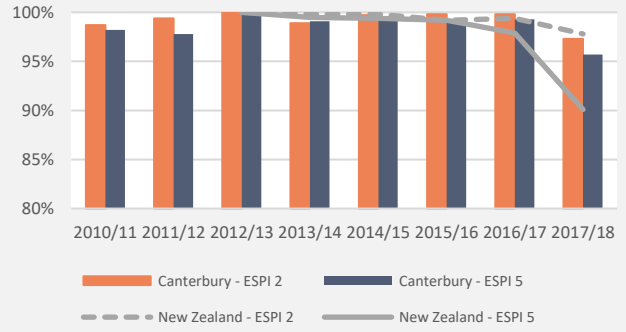
Improved performance against these measures requires us to make the most effective use of our limited resources to ensure wait times are minimised, while a year-on-year increase in volumes is delivered.

In this sense, these indicators are a marker of hospital efficiency and, with constrained capacity across our system, a proxy for how well we are managing the flow of patients across our services.

Data source: Ministry of Health Elective Services Website [15]

Measure: People receiving specialist assessment and treatment within set time frames

Base	Target			
17/18	19/20	20/21	21/22	22/23
ESPI2 97%	100%	100%	100%	100%
ESPI5 96%	100%	100%	100%	100%



PEOPLE ARE SUPPORTED ON DISCHARGE

Research indicates that people having a psychiatric admission have an increase vulnerability immediately following discharge, including higher risk of suicide, while those leaving hospital with a formal discharge plan and links to community-based services and supports, are less likely to experience early readmission.

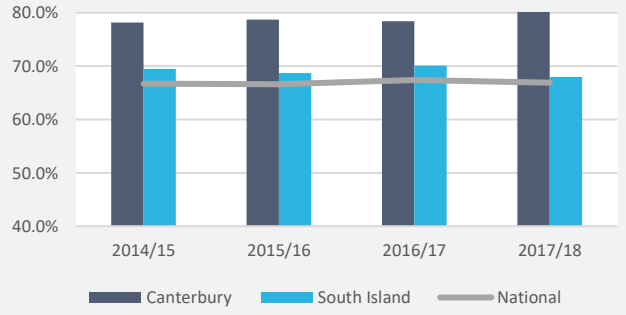
A responsive community support system and continuity of care is an essential element in helping people with complex conditions to maintain clinical and function ability and to establish a more stable lifestyle with improved quality of life.

In this sense, this indicator is a marker of good discharge planning, integration and the continuity of care between hospital and community services and an indicator of a strong and responsive mental health system.

Data Source: National Mental Health KPI Framework.

Measure: inpatients accessing community-based MH and AOD services within seven days of discharge

Base	Target			
17/18	19/20	20/21	21/22	22/23
80%	80%	80%	80%	80%



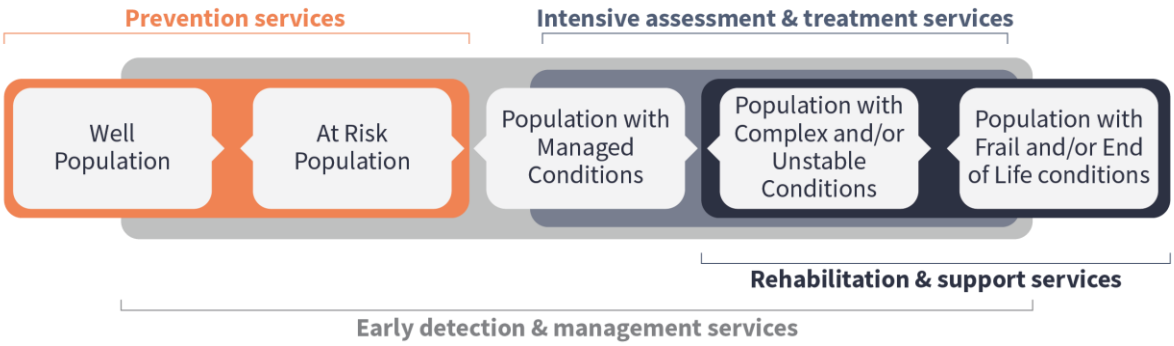
[14] This measure is a national performance measure indicator, but no longer a national health target, baselines differ to previously printed results having been reset from the quarter four year-end results (April-June) to full year (12 month) results.

[15] These measures are part of the national Elective Services Patient Flow Indicators (ESPIs) set and are a measure of whether DHBs are meeting expectations at key points in a patient's journey. ESPI 2 refers to the wait from referral to a person's first specialist assessment. ESPI 5 refers to the wait from the point from when treatment was agreed until treatment is delivered. The results presented refer to performance in the final month of each year (June).

THE YEAR AHEAD

What can you expect from us?

Statement of Performance Expectations



4.1 Evaluating our performance

As both the major funder and provider of health services in Canterbury, the decisions we make and the way in which we deliver services have a significant impact on people's health and wellbeing.

Having a limited resource pool and a growing demand for health services, we are strongly motivated to ensure we are delivering the most effective and efficient services possible.

Over the longer term, we evaluate the effectiveness of our decisions by tracking the health of our population against a set of desired population health outcomes, encompassed in our Outcomes Framework. These longer-term health indicators are highlighted in the earlier Monitoring Our Performance section.

On an annual basis, we evaluate our performance by providing a forecast of the services we plan to deliver and the standards we expect to meet. The results are then presented in our Annual Report at year end.

The following section presents the Canterbury DHB's Statement of Performance Expectations for 2019/20.

IDENTIFYING PERFORMANCE MEASURES

Because it would be overwhelming to measure every service delivered, services have been grouped into four service classes. These are common to all DHBs and reflect the types of services provided across the full health and wellbeing continuum (illustrated above):

- Prevention Services
- Early Detection and Management Services
- Intensive Assessment and Treatment Services
- Rehabilitation and Support Services.

Under each service class we have identified a mix of service measures that we believe are important to our community and stakeholders and provide a fair indication of how well the DHB is performing.

In health, the number of people who receive a service can be less important than whether enough of the right people received the service, or whether the service was delivered at the right time.

To ensure a balanced, well rounded picture, the mix of measures identified address four key aspects of service performance that matter most to our population:

Access (A)
Are services accessible, is access equitable, are we engaging with all of our population?

Timeliness (T)
How long are people waiting to be seen or treated, are we meeting expectations?

Quality (Q)
How effective is the service, are we delivering the desired health outcomes?

Experience (E)
How satisfied are people with the service they receive, do they have confidence in us?

SETTING STANDARDS

In setting performance standards, we consider the changing demography of our population, areas of increasing demand and the assumption that resources and funding growth will be limited.

Targets reflect the strategic objectives of the DHB: increasing the reach of prevention programmes; reducing acute or avoidable hospital admissions; and maintaining access to services - while at the same time reducing waiting times and delays in treatment.

We also seek to improve the experience of people in our care and public confidence in our health system.

While targeted interventions can reduce service demand in some areas, there will always be some demand the DHB cannot influence such as demand for maternity, dementia or palliative care services.

It is not appropriate to set targets for these services, however they are an important part of the picture of health need and service delivery in our region. Service level estimates have been provided to give context in terms of the use of resources across our health system.

Wherever possible, past years' results have been included to give context in terms of current performance levels and what we are trying to achieve.

SETTING PERFORMANCE EXPECTATIONS

With a growing diversity and persistent inequities across our population, achieving equity of outcomes is an overarching priority for the DHB. All of our targets are universal, with the aim of reducing inequities between population groups.

A number of focus areas have been identified as health priorities for Māori and the associated measures will be reported by ethnicity in our Annual Report.

Canterbury is still contending with the ongoing consequences of the earthquakes. The operational impact is being felt, most markedly, in an increased demand for mental health and emergency services and reduced capacity within our hospitals due to the loss of buildings and space. The relentless disruption from repairs and construction is also having a negative impact on services and on the wellbeing of our staff.

In considering this pressure and our reduced capacity, we have retained 2018/19 standards against a number of our discretionary measures. However, many of the performance targets presented in our forecast are national expectations set for all DHBs.

While we remain committed to maintaining high standards of service delivery, some national expectations (particularly those relating to increased delivery in our hospitals) will be particularly challenging in our current operating environment.

NOTES FOR THE READER

Rather than repeating footnotes, the following symbols have been used in the performance tables:

Δ Performance data is provided by external parties and baseline results can be subject to change, due to delays in invoicing or reporting.

† Performance data relates to the calendar year rather than the financial year.

◇ The measure is reported nationally as a key DHB performance target and in line with national performance reporting, fourth quarter (April-June) results are reported as the annual result.

E Services are demand driven and no targets have been set for these service lines. Estimated service volumes have been provided to give context in terms of the use of health resources

◆ This measure has been identified as a key focus area for Māori. Progress by ethnicity will be reported in the DHB's Annual Report.

4.2 Where does the money go?

In 2019/20 the DHB will receive approximately $1.945 billion dollars with which to purchase and provide the services required to meet the needs of our population.

The table below presents a summary of our anticipated financial split for 2019/20, by service class.

	2019/20
Revenue	Total $'000
Prevention	50,022
Early detection & management	377,932
Intensive assessment & treatment	1,229,107
Rehabilitation & support	288,649
Total Revenue - $'000	1,945,710
Expenditure	
Prevention	53,217
Early detection & management	414,022
Intensive assessment & treatment	1,344,274
Rehabilitation & support	314,667
Total Expenditure - $'000	2,126,180
Surplus/(Deficit) - $'000	(180,470)

4.3 Prevention services

WHY ARE THESE SERVICES SIGNIFICANT?

Preventative health services promote and protect the health of the whole population or targeted sub-groups, and influence individual behaviours by targeting changes to physical and social environments that engage, influence and support people to make healthier choices. These services include the use of legislation and policy to protect the population from environmental risks and communicable disease, education programmes and services to raise awareness of risk behaviours and healthy choices, and health protection services such as immunisation and screening programmes that support people to modify lifestyles and maintain good health.

By supporting people to make healthier choices, we can reduce the major risk factors that contribute to poor health such as smoking, poor diet, obesity, lack of physical exercise and hazardous drinking. High-need population groups are also more likely to engage in risky behaviours, or live in environments less conducive to making healthier choices. Prevention services are therefore one of our foremost opportunities to target improvements in the health of high-need populations and reduce inequities in health status and health outcomes. Prevention services are designed to spread consistent messages to a large number of people and can therefore also be a very cost-effective health intervention.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Population Protection Services – Healthy Environments				
These services address aspects of the physical, social and built environment in order to protect health and improve health outcomes.	Notes	2016/17 Result	2017/18 Result	2019/20 Target
Number of submissions providing strategic public health input and expert advice to inform policy in the region and/or nationally	Q [16]	116	78	E. 90
Licensed alcohol premises identified as compliant with legislation	Q [17]	79%	83%	90%
Networked drinking water supplies compliant with Health Act	Q [18]	96%	85%	97%

Health Promotion and Education Services				
These services inform people about risk factors and support them to make healthy choices. Success is evident through increased engagement and healthier choices.	Notes	2016/17 Result	2017/18 Result	2019/20 Target
Mothers receiving breastfeeding and lactation support in the community	A [19]	1,026	980	>600
Babies exclusively/fully breastfed at three months	Q [19]◆	60%	61%	70%
People provided with a Green Prescription for additional physical activity support	A [20]	3,800	4,087	>3,000
Green Prescription participants more active six to eight months after referral	Q	-	61%	>50%
Smokers, enrolled with a PHO, receiving advice and support to quit smoking (ABC)	Q [21]◆	90%	93%	90%
Smokers, identified in hospital, receiving advice and support to quit smoking (ABC)	Q ◆	96%	95%	95%
Pregnant women, identified as smokers at confirmation of pregnancy with an LMC, receiving advice and support to quit smoking (ABC)	Q [22]◆	93%	86%	90%

[16] Submissions are made to influence policy in the interests of improving and protecting the health of the population and providing a healthy and safe environment for our population. The number of submissions varies in a given year and may be higher (for example) when Territorial Authorities are consulting on long-term plans.

[17] New Zealand law prevents alcohol retailers from selling alcohol to young people aged under 18 years. The measure relates to Controlled Purchase Operations which involve sending supervised volunteers (under 18 years) into licensed premises. Compliance can be seen as a proxy measure of the success of education and training for licensed premises and reflects a culture that encourages a responsible approach to alcohol.

[18] This measure relates to the percent of (water) network supplies compliant with sections 69V and 69Z of the Health Act 1956. This includes all classes of supplies: large, medium, minor, small and rural agricultural.

[19] Evidence shows that infants who are breastfed have a lower risk of developing chronic illnesses during their lifetimes. Breastfeeding measures are part of the national Well Child/Tamariki Ora Quality Framework, data from providers is not able to be combined so performance from the largest provider (Plunket) is presented. Updated information has allowed baselines to be reset to present a full (12 month) result rather than the final quarter (six months) as previously presented.

[20] A Green Prescription is a health professional's written advice to a patient to be physically active, as part of their health management. Standards are set nationally and performance data is sourced from a biannual national patient survey competed by Research NZ on behalf of the Ministry of Health.

[21] The ABC programme has a cessation focus and refers to health professionals asking about smoking status, providing Brief advice and providing Cessation support. The provision of profession advice and cessation support is shown to increase the likelihood of smokers making quit attempts and the success rate of those attempts. The baselines for the hospital smoking measure has been reset to present full year (12 month) results, rather than the final quarter of each year (April-June).

[22] This data is sourced from the national Maternity Dataset Dataset which only covers approximately 80% of pregnancies nationally, as such, the results indicate trends rather than absolute performance. Standards have been set nationally in line with other smoking targets and baselines have been reset to present full year results.

Population-Based Screening Services				
These services help to identify people at risk and support earlier intervention and treatment. Success is evident through high levels of engagement with services.	Notes	2016/17 Result	2017/18 Result	2019/20 Target
Four-year-olds provided with a B4 School Check (B4SC)	A [23] ◆	93%	97%	90%
Four-year-olds (identified as obese at their B4SC) offered a referral for clinical assessment and family-based nutrition, activity and lifestyle intervention	Q [24] ◆	86%	98%	95%
Women aged 25-69 having a cervical cancer screen in the last 3 years	A [25] ◆	74%	74%	80%
Women aged 50-69 having a breast cancer screen in the last 2 years	A [25] ◆	76%	76%	70%

Immunisation Services				
These services reduce the transmission and impact of vaccine-preventable diseases. High coverage rates are indicative of a well-coordinated, successful service.	Notes	2016/17 Result	2017/18 Result	2019/20 Target
Children fully immunised at eight months of age	A [26] ◆	94%	94%	95%
Proportion of eight-month-olds 'reached' by immunisation services	Q	98%	98%	95%
Young people (Year 8) completing the HPV vaccination programme	A [27] † ◆	59%	65%	75%
Older people (65+) receiving a free influenza ('flu') vaccination	A [28] † ◆	63%	62%	75%

[23] The B4 School Check is the final core check, under the national Well Child/Tamariki Ora schedule, which children receive at age four. It is free and includes assessment of vision, hearing, oral health, height and weight, allowing concerns to be identified and addressed early.

[24] Obesity is particularly concerning in children as it is associated with a wide range of health conditions and increased risk of illness. It can also affect a child's educational attainment and quality of life. The referral allows families to access support to maintain healthier lifestyles. This is a national performance measure and baselines differ from those previously presented having been reset to reflect a full year (12 month) result rather than the final quarter result (Jan-June).

[25] Cervical cancer is one of the most preventable cancers and breast cancer one of the most common. Risk increases with age and regular screening reduces the risk of dying by allowing for earlier intervention and treatment. The measures refer to participation in national screening programmes and standards are set nationally.

[26] Immunisation at eight months is a national performance measure and the subset, children 'reached', is defined as children fully immunised and those whose parents have been contacted and provided with advice - but may have chosen to decline immunisations or opt off the National Immunisation Register. Baselines differ from those previously presented having been reset to reflect a full year (12 month) result rather than the final quarter of the year (April-June).

[27] The Human Papillomavirus (HPV) vaccination aims to protect young people from HPV infection and the risk of developing HPV-related cancers later in life. The programme consists of two vaccinations and is free to young women and men under 26 years of age. The target group for 2019/20 is the proportion of young people born in 2006 completing the programme. Baseline results refer to young women only, the programme was widened in 2019/20.

[28] Almost one in four New Zealanders are infected with influenza each year. Influenza vaccinations can reduce the risk of flu-associated hospitalisation and have also been associated with reduced hospitalisations among people with diabetes and chronic lung disease. The vaccine is especially important for people at risk of serious complications, including people aged over 65 and people with long-term or chronic conditions.

4.4 Early detection and management services

WHY ARE THESE SERVICES SIGNIFICANT FOR THE DHB?

Early detection and management services help to maintain, improve and restore people's health. These services include detection of people at risk, identification of disease and the effective management and coordination of services for people with long-term conditions. These services are by nature more generalist and accessible from multiple providers at a number of different locations. Providers include general practice, allied health, personal and mental health service providers and pharmacy, radiology and laboratory services providers.

The New Zealand health system is experiencing an increasing prevalence of long-term conditions, so-called because once diagnosed people usually have them for the rest of their lives. Some population groups suffer from these conditions more than others and prevalence increases with age. Cancer, cardiovascular disease, diabetes, and respiratory disease are the four leading long-term conditions for our population.

Our vision of an integrated system presents a unique opportunity. By promoting regular engagement with primary and community services, we can better support people to maintain good health, identify issues earlier and intervene in less invasive and more cost-effective ways. Our integrated approach is particularly effective where people have multiple conditions requiring ongoing intervention or support and reduces the burden of long-term conditions through improved self-management and the avoidance of complications, acute illness and unnecessary hospital admissions.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

General Practice Services				
These services support people to maintain their health and wellbeing. High levels of engagement with general practice are indicative of an accessible, responsive service.	Notes	2016/17 Result	2017/18 Result	2019/20 Target
Proportion of the population enrolled with a Primary Health Organisation (PHO)	A ◆	94%	93%	95%
Newborns enrolled with a PHO by three months of age	A [29]◆	80%	82%	85%
Young people (0-19) accessing brief intervention counselling in primary care	A [30]Δ	679	579	>500
Adults (20+) accessing brief intervention counselling in primary care	A [30]Δ	5,861	6,396	>5,500
Number of skin lesions (growths, including cancer) removed in primary care	A Δ	2,520	2,609	>2,000
Number of integrated HealthPathways in place across the health system	Q [31]	644	691	E. >600
Proportion of general practices using the primary care patient experience survey	E [32]	42%	62%	>65%

Long-Term Condition Services				
These services are targeted at people with high health needs with the aim of supporting people to better manage and control their conditions.	Notes	2016/17 Result	2017/18 Result	2019/20 Target
Number of spirometry tests provided in the community rather than in hospital	A [33]Δ	1,897	2,493	>2,000
People receiving subsidised diabetes self-management support when starting insulin	A Δ	381	400	>300
Population identified with diabetes having an HbA1c test in the last year	A [34]Δ◆	89%	90%	>90%
Population with diabetes having an HbA1c test and acceptable glycaemic control	Q [34]Δ◆	75%	74%	>60%

[29] This is a national performance measure and results have been reset in June 2019 as national data sources move from the PHO register to the National Enrolment Service (NES). The Ministry of Health provided estimates for DHB's annual enrolment rates for 2018 and 2019 based off the new system.

[30] The Brief Intervention Counselling service supports people with mild to moderate mental health concerns, including depression and anxiety. The service includes the provision of free counselling sessions (or extended consultations) and include face-2-face and phone consultations.

[31] Clinically designed HealthPathways support general practice teams to manage medical conditions, request advice or make secondary care referrals. The pathways support consistent access to treatment and care, no matter where in the health system people present.

[32] The Patient Experience Survey is a national online survey being rolled-out across the country to determine patients' experience in primary care and how well their overall care is managed. The information will be used to improve the quality of service delivery and patient safety.

[33] Spirometry is a tool for measuring and assessing lung function for a range of respiratory conditions. Providing this service in the community means people do not need to wait for a hospital appointment and conditions can be identified and treated earlier.

[34] Diabetes is a leading long-term condition and contributor to many other conditions. An annual HbA1c test (of blood glucose levels) is a means of assessing the management of people's condition. A level of less than 64mmol/mol reflects an acceptable blood glucose level.

Oral Health Services				
These services support lifelong health and wellbeing. High levels of enrolment and timely access to treatment are indicative of an accessible and efficient service.	Notes	2016/17 Result	2017/18 Result	2019/20 Target
Children (0-4) enrolled in DHB-funded oral health services	A [35]†◆	62%	76%	95%
Children (0-12) enrolled in DHB funded oral health services, who are examined according to planned recall	T [35]†◆	90%	88%	90%
Adolescents (13-17) accessing DHB-funded oral health services	A [35]†	61%	63%	85%

Pharmacy and Referred Services				
These are services which a health professional uses to help diagnose or monitor a health condition. While largely demand driven, timely access to services enables improved clinical decision-making and reduces unnecessary delays in treatment.	Notes	2016/17 Result	2017/18 Result	2019/20 Target
Number of laboratory tests completed for the Canterbury population	A Δ	2.8m	2.9m	E.<2.8m
Number of subsidised pharmaceutical items dispensed in the community	A Δ	6.8m	6.8m	E.<8m
People on multiple medications receiving medication management support	A [36]Δ	1,361	1,316	>1,200
People (65+) being dispensed 11 or more long term medications (rate per 1,000)	Q [37]†	4.2	4.0	E.<4.6
Number of community-referred radiology tests completed	A Δ	45,227	49,832	E.>40,000
People receiving their urgent diagnostic colonoscopy within two weeks	T [38]	94%	93%	90%
People receiving their Magnetic Resonance Imaging (MRI) scans within six weeks	T [38]	39%	41%	90%
People receiving their Computed Tomography (CT) scans within six weeks	T [38]	86%	69%	95%

[35] Oral health is an integral component of lifelong health and wellbeing. Early and regular contact with oral health services helps to sets lifelong patterns and reduce risk factors such as poor diet, which have lasting benefits in terms of improved nutrition and healthier body weights.

[36] The Medical Management Review programme helps to ensure the safe and appropriate use of medications. The programme offers more intense medication therapy assessments for the most complex patients and less complex medication use reviews for others.

[37] The use of multiple medications is most common in the elderly and can lead to reduce drug effectiveness or negative outcomes. Concerns include increased adverse drug reactions, poor drug interactions and higher costs for the system with little health benefits. Multiple medication use requires monitoring and review to validate whether all of the medications are complimentary and necessary. Data is sourced from the HQSC Atlas of Healthcare Variation.

[38] By improving clinical decision-making, timely access to diagnostics enables earlier and more appropriate intervention and treatment. This contributes to improved quality of care and health outcomes and by reducing long waits for diagnosis or treatment, improves people's confidence in the health system. A colonoscopy is a test that looks at the inner lining of a person's large intestine (rectum and colon). The radiology measures are national DHB performance indicators referring to wait times for non-urgent scans. Baselines differ to previously printed results, having been reset from the year-end results (June of each year) to full year (12 month) results.

4.5 Intensive assessment and treatment services

WHY ARE THESE SERVICES SIGNIFICANT?

Intensive assessment and treatment services are more complex services provided by specialists and health professionals working closely together. They are usually (but not always) provided in hospital settings, which enables the co-location of expertise and equipment. A proportion of these services are delivered in response to acute events, others are planned, and access is determined by clinical triage, treatment thresholds, capacity, and national service coverage agreements.

Timely access to intensive assessment and treatment can significantly improve people's quality of life through corrective action and is crucial to improving survival rates for complex illness such as cancer. Responsive services and timely access to treatment also enable people to establish more stable lives and result in improved confidence in the health system.

As an owner of specialist services, the DHB is committed to ensuring the quality of its service provision. Adverse events and delays in treatment, as well as causing harm to patients, drive unnecessary costs. Improved processes will support patient safety, reduce the number of events causing injury or harm, and improve health outcomes for our population.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Quality and Patient Safety				
These are national quality and patient safety markers and high compliance levels indicate robust quality processes and strong clinical engagement.	Notes	2016/17 Result	2017/18 Result	2019/20 Target
Staff compliant with good hand hygiene practice	Q [39◇]	83%	82%	80%
Inpatients (aged 75+) receiving a falls risk assessment	Q [39◇]	97%	97%	90%
Proportion of patients with a hospital acquired pressure injury	Q [39◇]	219	226	<204
Response rate to the national inpatient patient experience survey	E [40]	21%	22%	>30%
Proportion of patients who felt 'hospital staff included their family/Whānau or someone close to them in discussions about their care'	E [40]	68%	68%	65%

Specialist Mental Health and Alcohol and Other Drug (AOD) Services				
These are services for those most severely affected by mental illness and/or addictions who require specialist intervention and treatment. Reducing waiting times, while meeting demand for services, is indicative of a responsive and efficient service.	Notes	2016/17 Result	2017/18 Result	2019/20 Target
Proportion of the population (0-19) accessing specialist mental health services	A [41Δ]	3.7%	3.6%	>3.1%
Proportion of the population (20-64) accessing to specialist mental health services	A [Δ]	3.8%	3.8%	>3.1%
People referred for non-urgent mental health and AOD services seen within 3 weeks	T [42]	77%	74%	80%
People referred for non-urgent mental health and AOD services seen within 8 weeks	T	94%	91%	95%

[39] The quality markers are national DHB performance measures set to drive improvement in key areas. High compliance indicates robust quality processes and strong clinical engagement. Standards are set nationally and in line with national reporting results for the quality measures refer to the final quarter of each year (April-June). The 2017/18 results have been update to reflect the final quarter's results which were not previously available. Further detail and quarterly results for the full year can be found on the Health Quality and Safety Commission website www.hqsc.govt.nz. Pressure injuries are considered preventable and represent avoidable harm. They cause unnecessary pain and suffering and can cause disability or even death. Prevention of hospital acquired pressure injuries is a fundamental component of the Canterbury DHB Patient Safety Programme.

[40] There is growing evidence that patient experience is a good indicator of the quality of health services. Better experience, stronger partnerships with consumers, and patient and family-centred care have been linked to improved health, clinical, financial, service and satisfaction outcomes. The DHB inpatient experience survey covers four domains of patient experience: communication, partnership, co-ordination and physical and emotional needs. Baselines have been reset to align with internal reporting aligned and reflects full year, rather than quarterly results as previously presented. Further detail can be found on the Health Quality and Safety Commission website www.hqsc.govt.nz which includes results against these measures by quarter.

[41] There is a national expectation that around 3% of the population will need access to specialist level mental health services during their lifetime. The short timeframe presented does not reflect the extent of increase in demand for mental health services in Canterbury. Access rates in December 2010 (prior to the earthquakes) were 1.7% for youth and 2.2% for adults. Data is sourced from the national PRIMHD dataset and results are three months in arrears.

[42] Timely access to appropriate intervention and treatment, by reducing long waits for diagnosis or treatment, contributes to improved quality of care and health outcomes and improves people's confidence in the health system. This measure is a national DHB performance indicator (MH03) and standards are set nationally. Data is sourced from the national PRIMHD database and results are three months in arrears.

Maternity Services				
While largely demand driven, service utilisation is monitored to ensure services are accessible and responsive to need.	Notes	2016/17 Result	2017/18 Result	2019/20 Target
Women registered with a Lead Maternity Carer by 12 weeks of pregnancy	A [43]†◆	78%	n.a	80%
Number of maternity deliveries in Canterbury DHB facilities	A	6,048	6,056	E.6,000
Proportion of maternity deliveries made in Primary Birthing Units	Q [44]	14%	16%	>13%

Acute and Urgent Services				
Acute services are delivered in response to accidents or illnesses that have an abrupt onset or progression. Because early intervention can reduce the impact of the event, multiple options and shorter waiting times are indicative of a responsive system.	Notes	2016/17 Result	2017/18 Result	2019/20 Target
Number of acute demand packages of care provided in community settings	A [45] Δ	34,853	32,701	>30,000
Number of presentations at Canterbury Emergency Departments (ED)	A [46]	96,854	103,116	E.<110k
Proportion of the population presenting in ED (per 1,000 people)	Q	173	185	<190
Patients (referred with a high suspicion of cancer and a need to be seen within two weeks) receiving their first treatment within 62 days of referral.	T [47]	85%	95%	90%
Average acute inpatient length of stay (bed days per 1,000 people)	Q [48]	2.40	2.38	<2.35

Elective and Arranged Services				
Elective and arranged services are provided for people who do not need immediate hospital treatment. Reducing waiting times, while meeting demand for services, is indicative of a responsive and efficient service.	Notes	2016/17 Result	2017/18 Result	2019/20 Target
Number of First Specialist Assessments provided	A	72,049	73,913	E.>60,000
Proportion of First Specialist Assessments that were non-contact (virtual)	Q [49]	17%	19%	>15%
Number of planned care intervention delivered	A [50]	new	new	30,675
Proportion of people receiving their surgery on the day of admission	E [51]	91%	94%	>85%
Average elective inpatient length of stay (bed days per 1,000 people)	Q	1.54	1.57	<1.54
Number of outpatient consultations provided	A	672,348	694,629	E.>650k
Outpatient appointments where the patient was booked but did not attend (DNA)	Q [52]	4%	4%	<5%

[43] Early registration with a Lead Maternity Carer (LMC) is encouraged to promote the good health and wellbeing of mother and the developing baby. Data is sourced from the national Maternity Clinical Indicators report the 2017/18 data is yet to be released.

[44] The DHB aims to increase people's acceptance and confidence in using primary birthing units rather than having women give birth in secondary or tertiary facilities when it is not clinically indicated. This enables the best use of resources and ensures limited secondary services are more appropriately available for those women who need more complex or specialist intervention.

[45] Acute demand packages of care are provided through Canterbury's community-based Acute Demand Management Service with the aim of supporting people in their own homes or in the community rather than having people presenting to emergency or hospital for treatment.

[46] This measure is aligned to the national shorter stays in ED indicator and counts presentations to Christchurch and Ashburton Hospitals. In line with the national definition, this measure excludes those who do not wait and those with pre-arranged appointments.

[47] This is a national DHB performance measure and baselines differ to previously printed results, having been reset from final quarter (rolling six months from Jan-June of each year) to full year (12 month) results. There was a definition change for this measure in 2017/18, allowing patients to delay their treatment or for treatment to be delayed due to clinical considerations without impacting on the result, 2016/17 results are therefore not directly comparable.

[48] By shortening the average length of stay, the DHB delivers on the national improved hospital productivity priority and frees up beds and resources to provide more elective (planned) surgery. Addressing the factors that influence a patient's length of stay includes reducing the rate of complications and infection and integration activity to support patients to return home sooner, which improve patient outcomes. This is a national DHB performance indicator and standards are set nationally.

[49] Non-contact assessments are those where assessment is provided without the need (or the wait) for a hospital appointment. This direction aligns to the DHB's vision of reducing waiting times and unnecessary delay in treatment for patients.

[50] The new planned care intervention measure reflects a change in national expectation that continues to recognise the delivery of elective surgery but also recognises the delivery of minor procedures and non-surgical interventions that are required to improve people's health and wellbeing. The new measure also recognised interventions delivered in both hospital and community settings. Canterbury's planned care interventions target is made up of three components: elective surgical discharges (19,182), Minor Procedures (11,385) and Non-Surgical Interventions (108).

[51] With the introduction of the DHB's new patient information system the definition for this measure has been reset. Previous year's results are not directly comparable.

[52] When patients fail to turn up to scheduled appointments, it can negatively affect their recovery and long-term outcomes and it is a costly waste of resources for the DHB. This measure is the proportion of all medical and surgical outpatient appointments where the patient was expected to attend on the day, but did not.

4.6 Rehabilitation and support services

WHY ARE THESE SERVICES SIGNIFICANT?

Rehabilitation and support services provide people with the assistance they need to live safely and independently in their own homes, or regain functional ability, after a health-related event. Services are mostly provided to older people, or people with mental health or complex personal health conditions, following a clinical 'needs assessment'. Support services also include palliative care for people who have end-of-life conditions. It is important that they and their families are appropriately supported so that the person is able to live comfortably and have their needs met in a holistic and respectful way, without undue pain and suffering.

These services are considered to provide people with a much higher quality of life as a result of being able to stay active and positively connected to their communities. Even when returning to full health is not possible, access to responsive support services enables people to maximise their independence. In preventing deterioration, acute illness, crisis or deterioration of function, these services have a major impact on the sustainability of our health system, by reducing acute service demand and the need for more complex interventions or residential care. These services also support patient flow by enabling people to go home from hospital earlier.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Assessment, Treatment and Rehabilitation (AT&R) Services				
These services restore or maximise people's health or functional ability following a health-related event such as a fall, heart attack or stroke. Service utilisation is monitored to ensure people are appropriately supported after an event.	Notes	2016/17 Result	2017/18 Result	2019/20 Target
People accessing community-based pulmonary rehabilitation courses	A [53]	325	270	>250
People (65+) accessing the community-based falls prevention service	A [54]	1,815	1,653	>1,500
People supported by the Community Rehabilitation and Support Team (CREST)	A [55Δ]	1,741	1,839	>1,600
Proportion of inpatients referred to an organised stroke service after an acute event	Q [56]	81%	80%	80%
Proportion of AT&R inpatients discharged to their own home rather than ARC	Q [57]	88%	86%	>80%

Home-Based and Community Support Services				
These are services designed to support people to maintain functional independence. Clinical assessment ensures access to services is appropriate and equitable.	Notes	2016/17 Result	2017/18 Result	2019/20 Target
People supported by district nursing services	A Δ	7,798	7,698	E. >7,000
People supported by long-term home-based support services	A Δ	7,922	8,554	E. >8,000
Proportion of the population (65+) receiving long-term, home-based support	A Δ	9.8%	9.7%	E. 10%
People supported by long-term home and community support services who have had a clinical assessment of need using the InterRAI assessment tool	Q [58Δ]	97%	92%	95%
People supported by hospice or home-based palliative services	A Δ	4,060	4,033	E. 4,000
People with Advance Care Plans in place to support end of life care	A	-	697	>700
Proportion of people with Advance Care Plans, dying in their place of choice	Q [59]	-	68%	>70%

[53] Respiratory and lung diseases are major contributor to avoidable hospital admissions in Canterbury, particularly over winter. Pulmonary rehabilitation programmes are designed to help patients with Chronic Obstructive Pulmonary Disease (a type of obstructive lung disease) to manage their symptoms and learn breathing, lifestyle and day-to-day living techniques to help them better manage their condition.

[54] Falls are one the leading causes of hospital admission for people aged over 65. The aim of the Falls Prevention Programme is to provide better care for people both 'at-risk' of a fall, or following a fall, and to support people to stay safe and well in their own homes.

[55] The Community Rehabilitation Enablement and Support Team (CREST) provides a range of short-term home-based rehabilitation services to facilitate early discharge from hospital, or avoid admission entirely through proactive referral. The measure is the number of people having received unique packages of care.

[56] This is a national DHB performance measure. Baselines differ to previously printed results, being reset from final quarter to full year results, one quarter in arrears.

[57] While living in Aged Residential Care (ARC) is appropriate for a small proportion of our population, for most people remaining safe and well in their own homes provides a higher quality of life. A discharge home reflects the effectiveness of services in terms of assisting that person to regain their functional independence.

[58] The International Residential Assessment Instrument (InterRAI) is a suite of evidence-based geriatric assessment tools used nationally to support clinical decision making and care planning. Evidence-based practice guidelines ensure people receive appropriate and equitable access to services.

[59] This measure is based on the number of people who have died during the period, where we know the location of death, and this correspondences with their wishes as articulated in their Advance Care Plan. These people may have created their Plans in an earlier period.

Respite and Day Support Services				
These services provide people with a break from a routine or regimented programme, so that crisis can be averted or a specific health need can be addressed. Largely demand driven, service utilisation is monitored to ensure services are accessible.	Notes	2016/17 Result	2017/18 Result	2019/20 Target
People supported by community-based mental health crisis respite services	A [Δ]	904	1,081	E.>850
Occupancy rate of mental health crisis respite beds	A[60Δ]	73%	85%	85%
Older people supported by day care services	A[61Δ]	728	727	E.>550
Older people accessing aged care respite services	A[Δ]	1,715	1,697	E. <1,500
People supported by aged care respite services, being discharged to their own home	Q[62Δ]	86%	84%	>80%

Aged Residential Care Services				
The DHB subsidises ARC for people who meet the national thresholds for care. While our ageing population will increase demand, slower demand growth for lower-level care is indicative of more people being supported in their own homes for longer.	Notes	2016/17 Result	2017/18 Result	2019/20 Target
Proportion of the population (75+) accessing rest home level services in ARC	A [63Δ]	4.6%	4.7%	E.<5.0%
Proportion of the population (75+) accessing hospital-level services in ARC	A [Δ]	6.0%	6.3%	E.6.5%
Proportion of the population (75+) accessing dementia services in ARC	A [Δ]	2.4%	2.7%	E. 2.6%
Proportion of the population (75+) accessing psychogeriatric services in ARC	A [Δ]	0.8%	0.8%	E. 0.8%
People entering ARC having had a clinical assessment of need using InterRAI	Q [64Δ]	88%	93%	95%

[60] Occupancy rates provide an indication of a service's 'capacity'. The aim is to maintain enough beds to meet demand requirements (with some space to flex) but not too many beds to imply that services are under-utilised and resources could be better directed to other areas.

[61] The measure includes people accessing day care services in the community and in ARC, largely aged 65+ but including people close in age and interest.

[62] Respite services aim to support people for short durations, to regain function or to give carers a break. The proportion of people being discharged home (rather than staying on in ARC) reflects the effectiveness of services in terms of assisting people to maintain or regain their functional independence.

[63] The Canterbury region has historically had higher ARC rates than national levels and by providing more services that help older people maintain functional independence for longer, they are able to remain in their own homes reducing the demand for rest-home-level care. Access rates for more complex care such as dementia and psychogeriatric care are less amenable and more attributable to the aging of our population. Measures refer to people accessing DHB funded ARC services and exclude people choosing to enter ARC privately or people living independently in retirement villages.

[64] The International Residential Assessment Instrument (InterRAI) is a suite of evidence-based geriatric assessment tools used nationally to support clinical decision making and care planning. Evidence-based practice guidelines ensure people receive appropriate and equitable access to services.

Statement of Financial Performance Expectations

4.7 Canterbury's financial outlook

Funding from the Government, via the Ministry of Health, is the main source of DHB funding. This is supplemented by revenue agreements with ACC, research grants, donations, training subsidies, patient co-payments and service payments from other DHBs.

Like the rest of the health sector, the Canterbury DHB is experiencing growing financial pressure from increasing demand and treatment costs, increasing wage settlements and heightened public expectations.

However, unlike other DHBs, we are also having to manage the extraordinary impacts of the country's largest natural disaster. These include: revenue volatility resulting from population and deprivation shifts; increased service demand; and the operational challenges of providing services in the midst of a significant and ongoing repair programme.

It is incredibly challenging to meet financial expectations while addressing the heightened needs of a more vulnerable population and rebuilding almost all of our entire health infrastructure.

Earthquake and rebuild costs continue to be evident in a number of areas: increased treatment costs; additional outsourcing to support service delivery while our capacity is reduced; unplanned repair costs; construction delays; depreciation; and capital charges.

Lost capacity costs: Our theatre and bed capacity was reduced by the earthquakes and the Christchurch Hospital redevelopment is considerably behind schedule. Construction costs are escalating and while we wait for the new facilities to be complete we are incurring significant additional costs to hire theatres and outsource surgeries. The delays are also impacting on our ability to achieve anticipated savings from the consolidation of services.

Repair costs: A significant proportion of our repair work is not covered by insurance proceeds. While we received the maximum $320 million insurance pay-out under our collective sector policy, damage estimates were over $518 million. Our repair programme has required, and will continue to require, ruthless prioritisation to remain affordable.

Depreciation and capital charges: Included in the cost pressures related to the earthquakes are the depreciation and capital charges the DHB must pay to the Crown. Because these are driven off upward movements in asset valuations, our repair work has resulted in significant additional unanticipated charges. In 2019/20, Canterbury will pay an estimated $54 million in capital charges to the Crown, based on existing capital charge regulations (currently under review by Crown agencies).

Increasing demand costs: Demand patterns have also changed. In line with other international recovery profiles, the post-disaster impacts on the health and well-being of our population are being acutely felt. This is particularly evident in the increased demand for mental health services with new presentations to children's mental health services especially high.

Post-earthquake population increases, changes in demand, and workforce shortages also mean that even after the DHB's new Outpatient and Acute Services facilities come online, capacity will continue to be stretched. Further solutions will need to be found to meet growing demand and further investment in facilities, technology and workforce will be needed.

In addition to the unique earthquake-related aspects the Canterbury Health Systems will also need to response to the yet emergent impacts of the March 2019 terrorist event.

Multi Employment Collective Agreement (MECA) settlement costs: While DHB received partial funding to offset some of the cost, the MECAs settled in the past year significantly exceeded the affordability parameters of the DHB. The flow on impact of these settlements, along with the substantial claims of unsettled expired MECAs and expectations of staff on Individual Employment Agreement, will put immense pressure on the DHB's financial sustainability.

Moving forward: There is no easy solution, and improving the health of our population is the only way to reduce the demand curve. These savings will be made, not in dollar terms, but in costs avoided through earlier intervention and more effective use of available resources. While these gains may be slow, this is the basis on which we will build a more effective and sustainable health system. The DHB is committed to continuing its deliberate strategy in this regard.

The DHB is also working with the Ministry of Health and other key government agencies to establish a stable and sustainable pathway forward, which considers our unique operating challenges. In doing so we are committed to continuing to review services and service models to ensure we are using our resources in the most effective and efficient way. Anticipated service changes for the coming year are highlighted in the DHB's Annual Plan.

4.8 Planned results

It is anticipated that the Canterbury DHB will receive $1.945 billion of total revenue, from all sources, with which to meet the needs of our population and the significant cost increases of Multi Employment Collective Agreements and other pay settlements reached in (and impacting on) 2019/20.

The Canterbury DHB is forecasting a $180.4 million deficit result for the 2019/20 year.

The forecasted deficit takes into account Canterbury's allocated share of population based funding (demographic and cost pressures). It also assumes that the three-year fixed term $5.5 million annual funding provided to cover increased demand for mental health services following the earthquakes (and due to expire in 2018/19) will be 'rolled-over' indefinitely until an alternative funding mechanism for these increased costs is addressed by the Crown. The forecast excludes any cost associated with the flow-on impact of the Holidays Act liability, which is being actively assessed by the DHB sector.

OUT-YEARS' SCENARIO

The post-earthquake reality in Canterbury will continue to create a high level of uncertainty with regards to both revenue and expenditure in out-years.

Our remaining unspent earthquake insurance proceeds are held by the Crown on behalf of the DHB. We are able to draw down these proceeds as revenue to offset earthquake-related operating repair costs and as equity to offset capitalised repair costs. However, equity drawdowns incur a capital charge in addition to the operational impact of depreciation.

Interest, depreciation and capital charge costs arising from earthquake repairs, new facilities and assets revaluation will have a significant impact on our out-year financials. These costs will increase significantly on completion of the Hagley Building on the Christchurch Hospital campus (2019/20) and the mental health services facilities at Hillmorton for services to relocate from The Princess Margaret Hospital (2022/23).

The combined annual depreciation, overdraft interest and capital charge will increase from $79 million in 2018/19 to approximately $152 million by 2022/23.

The interplay between the nature of earthquake repairs, new building codes and construction cost escalations continues to be dynamic. Anticipated repair costs have been included but an accurate total overall cost is still difficult to pre-determine.

Also, due to the recognition of insurance proceeds in 2012/13 (as required under current NZ accounting standards and resulting in an 'atypical' surplus of $287M in 2012/13), some future costs are not able to be offset with the corresponding inflow of insurance proceeds. This creates a timing mismatch in current and out-years.

4.9 Major assumptions

Revenue and expenditure estimates for out-years have been based on current government policy, service delivery models and demand patterns. Changes in the complex mix of any of the contributing factors will impact on our results. In preparing our financial forecasts, we have made the following assumptions:

- The DHB will retain early payment arrangements.
- Out-years funding is assumed at the Treasury's mid-scenario forecasts for Canterbury DHB.
- Operating deficits will be fully funded as equity. The DHB has retained this assumption despite recent experiences where the deficit funded has been significantly less than the deficit incurred.
- Capital charge for out-years is based on the current rate of 6%. Any rate change in the future is assumed to be financially neutral.
- The cost differential between interest and capital charge associated with the debt/equity swap of pre-approved debt for the Hagley Building and Outpatient facility is fully funded.
- Any targeted funding to meet additional mental health service provision will be sustainable over the longer-term.
- The $5.5 million per annum funding provided by the Ministry of Health in 2016 for a three year period, to cover increased demand for mental health services following the earthquakes, (planned to expire in 2019) will continue indefinitely, and the Ministry will actively work with Canterbury DHB to ensure adequate funding to meet Mental Health service pressures.
- Costs of compliance with any new national expectations will be cost neutral or fully funded, as will any legislative changes, sector reorganisation or service devolvement.
- Assumption of responsibility for the population of the Chatham Islands will be cost neutral to the Canterbury DHB. The DHB is yet to clarify the funding stream to enable remediation of local facilities inherited in 2015.
- Funding for pay equity settlements will be cost-neutral and fully funded.
- $113 million (being the forecast, as at June 2019, of undrawn portion of Canterbury's $320 million earthquake settlement proceeds transferred to the Crown to minimise capital charge expenses), will be available to the DHB to fund the earthquake repair and reinstatement programme as required.
- As agreed with the Ministry of Health, the revenue and equity timing of the earthquake insurance draw down will be flexible and based on DHB requests rather than necessarily matching the earthquake capital and operating repair spend for a particular year.
- Capital charge associated with earthquake settlement proceeds redrawn as equity will be reviewed alongside the wider Crown proposal to modify the existing capital charge regulations.

- Additional saving targets requiring service changes and/or Ministerial consent are approved in a timely manner.
- Work will continue on the redevelopment of Canterbury facilities in accordance with the detailed business case agreed with the Ministry and previous Cabinet. Associated capital expenditure and resulting capital charge that will take place during the term of this Plan have been included, where appropriate.
- Revaluations of land and buildings will continue, and will impact on asset values. In addition to regular periodic revaluations, further impairment in relation to earthquakes may be necessary.
- Employee cost increases for expired wage agreements, including minimum wage flow-on impact if any, will be settled on fiscally sustainable terms, inclusive of step increases and the impact of accumulated leave revaluation. External provider increases will also be settled within available funding levels.
- Treatment related costs will increase in line with known inflation factors and foreseen adjustments for the impact of growth within services.
- National and regional savings initiatives and benefits will be achieved as planned.
- Transformation strategies will not be delayed or derailed due to sector or legislative changes and investment to meet increased earthquake-related demand will be prioritised and approved, in line with the Board's strategy.
- There will be no further disruptions associated with natural disasters or pandemics. Revenue and expenditure have been budgeted on current and expected operations with no further disruptions. Noting that the impacts of New Zealand's recent terrorist induced mass casualty incident are as yet unquantified.

4.10 Bridging the gap

While health continues to receive a large share of government funding, if we are to be sustainable, we must rethink how we will meet our population's need within a more moderate growth platform.

Since establishing our vision in 2006, we have been purposeful and deliberate in planning how we would meet growing demand for health services and make the best use of the resources we have available.

In the past eight years, our ability to absorb revenue and cost impacts related to the earthquakes has largely been delivered by slowing our growth rate of acute demand, reducing our dependence on aged residential care, reorganising laboratory services, and removing waste and duplication from our system.

Alongside the effective transformation of our health system, we are also focused on delivering efficiency and quality improvements to take the wait and waste out of our system. In the coming year, we will consider all options and opportunities to bridge the gap between revenue and expenditure including:

- Integrating systems, services and processes to remove variation, duplication and waste.
- Empowering clinical decision-making to reduce delays and improve the quality of care.
- Improving production planning to ensure we use our resources in the most effective way.
- Focusing expenditure on areas that are essential, and reducing the outsourcing of services.
- Prioritising investment into services that meet the most immediate demand, deliver maximum health benefits and are sustainable longer-term.
- Aligning policies and practice with other DHBs and with national service specifications to reduce treatment and service costs.
- Acknowledging fiscal constraints and limitations when considering the implementation of new technologies, initiatives or services.
- Reviewing service capacity and costs across heavily subsidised service areas and exploring alternative options for service delivery.
- Restraining cost growth including moderating treatment, back office, support, and FTE costs.
- Supporting the South Island Alliance to implement tighter cost controls and make purchasing improvements to limit the rate of cost growth by taking a lead in the regional Procurement and Supply Chain Workstream.

Anticipated service changes for 2019/20 are outlined in the DHB's Annual Plan.

4.11 Capital investment

NATIONAL BUSINESS CASES

The detailed business case for the redevelopment of the Christchurch Hospital site was approved in March 2013. Construction of both the Outpatients and Hagley Buildings have been significantly delayed. Whilst the Outpatients Building is now operational (November 2018), the Hagley Building is not scheduled for completion until the second half of 2019.

The detailed business case for replacement of our patient administration systems with one South Island Patient Information Care System was approved in 2014. Burwood was the first go-live site and Ashburton and Christchurch Hospital went live in 2018/19.

The detailed business case for the relocation of mental health services from The Princess Margaret Hospital, was approved in December 2018. This project is

expected to be completed by 2023. A further business case will need to be developed for the relocation of Child and Family outpatient services, which were excluded in the approved business case.

A detailed business case for the future of the Christchurch Hospital Campus is being progressed alongside a re-purposed programme business case, incorporating key facility redevelopments to address the future service needs including but not limited to: inpatient; ambulatory; food services; laboratory; and oncology services. The critical projects and facilities concerned are an integral part of the blueprint for the ongoing development of the campus, as foreshadowed in the approved 2013 detailed business case outlined above. The plan addresses immediate needs as well as providing the foundation for the longer development solution for the campus to meet service and capacity demands.

The DHB has also completed an initial strategic assessment in regards to investment in a facility for Canterbury's tertiary laboratory and pathology services. This was submitted to the Ministry of Health for consideration and will be considered alongside the programme business case outlined above.

CAPITAL EXPENDITURE

Subject to the appropriate approvals, Canterbury's capital expenditure budget for 2019/20 totals $584 million, and is comprised of:

- $519 million for the Hagley Building (including CDHB funded scope)
- $7 million progress spend for the approved business case to relocate inpatient mental health services from The Princess Margaret Hospital
- $14 million for the capital expenditure portion of the strategic earthquake programme of works (excluding EQ works related spend on CDHB funded scope for Hagley accounted for above).
- $3 million in progress payments for the South Island Patient Information Care System and Electronic Medications (EMEDS) system.
- $5 million for Hillmorton AT&R and PSAID (Psychiatric Services for Adults with an Intellectual Disability) facility upgrade.
- $36 million for other baseline new/replacement assets and systems.

(Note: Circa $503 million relating to the Hagley Building is Crown equity funded which will be transacted as non-cash transfer).

Anticipated investment for out-years includes:

- Strategic Information Technology developments towards a digital hospital including: further implementation of the Patient Information Care System, Electronic Medication Management, HealthOne and investment in the patient portal.
- Repair and reinstatement of the Christchurch Hospital Energy Centre and Carpark.
- Completion of the Akaroa IFHC redevelopments in line with approvals.
- Continued repair and reinstatement of assets under the DHB's earthquake repair programme.
- Relocation of Child and Family mental health outpatient services currently located on The Princess Margaret Hospital site.
- Repurposing of the Canterbury Health Laboratories building per outcome of future detailed planning.
- Further Christchurch Hospital Campus redevelopment, incorporating the future of services currently located in earthquake damaged and/or below building code facilities (Riverside, Parkside and Food Services buildings) and other key facilities such as the Oncology building.

Out-years capital planning will also consider the future use of existing buildings and facilities, in line with our earthquake repair programme, and in response to population growth and service demand. This will include buildings on the Christchurch Hospital and Hillmorton Hospital campuses.

Any lengthy construction delays, changes in building codes or cost price increases for major redevelopment or repair projects are likely to have a significant impact on planned expenditure.

4.12 Debt and equity

In February 2017, all DHB Crown debts were converted to equity as part of the debt/equity translation process. Effective from 2016/17, DHBs have no Crown debt. The pre-approved debt for the new Hagley Building will also be translated to equity, with appropriate funding to offset the additional cost arising from the difference between interest and capital charge rates.

The Canterbury DHB repaid equity to the Crown of $180 million as part of our contribution towards the Burwood and Christchurch Hospital redevelopments.

The extent of damage to Canterbury DHB's insured facilities and equipment is well in excess of $518 million. However, the collective sector insurance in place at the time of the earthquake meant we were only able to access a total maximum loss capacity of $320 million. The gap between the insurance settlement and the total cost of the repairs will need to be met from our existing funds.

In June 2014, we paid $290 million (being the unspent portion of the $320 million as at June 2014) of our earthquake settlement insurance proceeds to the Crown to minimise capital charge expenses (arising from an abnormal surplus through recognising the settlement proceeds as income under current NZ accounting standards). As agreed with the Ministry of Health, the $290 million is being progressively drawn down to fund the ongoing earthquake repair work.

The forecast amount drawn down as at 30 June 2019, is $177 million (a mix of revenue and equity) leaving a balance of $113 million yet to be drawn. This is now unlikely to be sufficient in light of unplanned costs coming out of this settlement related to the redevelopment of the Hagley Building and completion of the Boiler House and Energy Centre.

Taking into account projected equity movements over the next four years, the Crown's equity in the DHB will rise from $663 million as at June 2019 to $1.298 billion by June 2023. The higher equity balance will result in a significant increase in the capital charge payable to the Crown.

4.13 Additional considerations

DISPOSAL OF LAND

Under the NZ Public Health and Disability Act, no DHB may dispose of land without approval of the Minister of Health. Ministerial approval will only be given where the DHB has complied with its statutory clearance and public consultation obligations under the Act.

Anticipated activity for 2019/20 includes the potential disposal of a parcel of land on St Asaph Street and two parcels of land on Tuam Street within the Health Precinct as part of a land swap with the Crown (acting by and through Land Information New Zealand).

We are yet to determine the future of the former Christchurch Women's Hospital site in the central city and the Princess Margaret Hospital site in Cashmere. Over the coming year we will also consider the future use of all of our rural hospitals.

ACTIVITIES FOR WHICH COMPENSATION IS SOUGHT

No compensation is sought by the Crown in accordance with the Public Finance Act Section 41(D).

ACQUISITION OF SHARES

Before the Canterbury DHB or any of our associates or subsidiaries can subscribe for, purchase, or otherwise acquire shares in any company or other organisation, our Board will consult the responsible Minister(s) and obtain their approval.

ACCOUNTING POLICIES

The accounting policies adopted are consistent with those in the prior year. For a full statement of accounting policies, refer to Appendix 3.

4.14 Group Statement of Financial Performance (Comprehensive Income)

	2017/18 Actual $'000	2018/19 Forecast $'000	2019/20 Plan $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000
REVENUE						
Ministry of Health revenue (Note 1)	1,647,882	1,744,116	1,841,187	1,916,465	2,003,288	2,086,198
Other government revenue	36,948	36,987	38,778	39,996	41,596	43,260
Earthquake repair revenue redrawn	3,240	4,460	10,800	14,700	10,000	2,200
Other revenue	48,031	52,665	54,945	58,934	63,032	67,033
Total Revenue	**1,736,101**	**1,838,228**	**1,945,710**	**2,030,095**	**2,117,916**	**2,198,691**
EXPENSE						
Personnel	755,125	829,945	895,964	945,495	994,158	1,038,865
Outsourced (Note 2)	28,801	31,127	29,193	28,325	27,753	27,188
Clinical supplies	144,638	134,853	159,795	174,358	182,813	190,451
Earthquake building repair costs	3,240	4,460	10,800	14,700	10,000	2,200
Infrastructure & non clinical (excl Earthquake repairs)	99,891	115,131	119,360	125,552	127,386	129,932
Payments to non-CDHB providers	679,357	756,453	773,439	762,475	784,943	799,504
Total Expense Before Depreciation & Capital Charge	**1,711,052**	**1,871,969**	**1,988,551**	**2,050,905**	**2,127,053**	**2,188,140**
Surplus/(Deficit) Before Depreciation & Capital Charge	**25,049**	**(33,741)**	**(42,841)**	**(20,810)**	**(9,137)**	**10,551**
Depreciation and amortisation	58,655	54,085	83,165	83,066	73,465	74,779
Capital charge and interest expense	30,353	24,753	54,464	69,518	72,672	77,458
Total Depreciation, Capital Charge & Interest Expense	**89,008**	**78,838**	**137,629**	**152,584**	**146,137**	**152,237**
Surplus/(Deficit)	**(63,959)**	**(112,579)**	**(180,470)**	**(173,394)**	**(155,274)**	**(141,686)**
OTHER COMPREHENSIVE REVENUE & EXPENSE						
Revaluation of property, plant & equipment	-	137,346	-	-	-	-
Total Comprehensive Income/(Deficit)	**(63,959)**	**24,767**	**(180,470)**	**(173,394)**	**(155,274)**	**(141,686)**

Note 1: Includes Inter District Flow and Inter-DHB revenue

Note 2: Excludes outsourced electives payments to Non-CDHB Providers

4.15 Group Statement of Financial Position

	30/06/18 Actual $'000	30/06/19 Forecast $'000	30/06/20 Plan $'000	30/06/21 Plan $'000	30/06/22 Plan $'000	30/06/23 Plan $'000
CROWN EQUITY						
Contributed capital	132,470	274,070	924,852	1,134,575	1,384,850	1,560,536
Revaluation reserve	289,058	426,404	426,403	426,403	426,403	426,403
Accumulated surpluses	74,743	(37,836)	(218,306)	(391,700)	(546,974)	(688,660)
Total Equity	**496,271**	**662,638**	**1,132,949**	**1,169,278**	**1,264,279**	**1,298,279**
REPRESENTED BY:						
CURRENT ASSETS						
Cash & cash equivalents	1,678	4,824	627	627	36,494	11,012
Trade & other receivables	90,396	96,846	96,848	96,848	96,848	96,848
Inventories	11,170	13,209	13,208	13,208	13,208	13,208
Restricted assets	14,577	14,685	14,685	14,685	14,685	14,685
Investments	750	750	750	750	750	750
Total Current Assets	118,571	130,314	126,118	126,118	161,985	136,503
CURRENT LIABILITIES						
NZHPL sweep bank account	17,376	36,574	63,024	17,486	-	-
Trade & other payables	111,190	123,995	123,995	123,995	123,995	123,995
Employee benefits	171,363	180,342	180,342	180,342	180,342	180,342
Restricted funds	14,593	14,701	14,701	14,701	14,701	14,701
Total Current Liabilities	314,522	355,612	382,062	336,524	319,038	319,038
Net Working Capital	(195,951)	(225,298)	(255,944)	(210,406)	(157,053)	(182,535)
NON CURRENT ASSETS						
Property, plant, & equipment	670,749	860,003	1,358,112	1,348,775	1,392,096	1,453,676
Intangible assets	27,634	33,818	36,667	36,795	35,122	33,024
Restricted assets	16	16	16	16	16	16
Total Non-Current Assets	698,399	893,837	1,394,795	1,385,586	1,427,234	1,486,716
NON CURRENT LIABILITIES						
Employee benefits	6,177	5,901	5,902	5,902	5,902	5,902
Total Non-Current Liabilities	6,177	5,901	5,902	5,902	5,902	5,902
Net Assets	**496,271**	**662,638**	**1,132,949**	**1,169,278**	**1,264,279**	**1,298,279**

4.16 Group Statement of Movements in Equity

	2017/18 Actual $'000	2018/19 Forecast $'000	2019/20 Plan $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000
Total equity at beginning of the year	517,833	496,271	662,638	1,132,949	1,169,278	1,264,279
Total comprehensive revenue and expense for the year	(63,959)	24,767	(180,470)	(173,394)	(155,274)	(141,686)
OTHER MOVEMENTS						
EQUITY REPAYMENTS						
Annual depreciation funding repayment	(1,861)	(1,861)	(1,861)	(1,861)	(1,861)	(1,861)
EQUITY INJECTIONS						
Earthquake repair capital redrawn	9,258	54,650	29,000	5,000	47,692	-
Kaikoura facility contribution	2,000	-	-	-	-	-
Operating deficit support (Note 3)	35,000	81,611	112,579	180,470	173,394	155,274
Approved Mental Health Relocation DBC (Note 4)	-	-	7,503	26,114	31,050	14,333
Approved Facilities Redevelopment DBC (Note 5)	-	-	-	-	-	7,940
New facilities redevelopment assets transferred from the Crown - original equity value (Note 6)	(232,985)	7,200	278,960	-	-	-
Debt to Equity swap - new facilities (Note 6)	85,000	-	224,600	-	-	-
Debt to equity swap - debt balance as at June 2016	145,985	-	-	-	-	-
Total Equity at End of the Year	**496,271**	**662,638**	**1,132,949**	**1,169,278**	**1,264,279**	**1,298,279**

Note 3: Assume operating deficit support is fully funded and received in the following year.

Note 4: Figures reflect indicative progressive draw down of equity.

Note 5: Relates to balance of 2012/13 approved Facilities Redevelopment DBC funding (for Parkside). The $7.9M represents the original approved amount for Parkside of $21M less $13.06M transferred to Hagley building per 21 February Minister of Health letter advice.

Note 6: 2019/20 amount is indicative only and subject to the final cost and agreed debt vs equity split of the Christchurch Hospital Hagley Building asset to be transferred from the Ministry of Health.

4.17 Group Statement of Cash Flow

	2017/18 Actual $'000	2018/19 Forecast $'000	2019/20 Plan $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000
CASH FLOW FROM OPERATING ACTIVITIES						
Cash provided from:						
Receipts from Ministry of Health	1,642,515	1,741,256	1,841,187	1,916,465	2,003,288	2,086,198
Earthquake repair revenue redrawn	3,240	4,460	10,800	14,700	10,000	2,200
Other receipts	67,993	90,239	92,814	97,830	103,411	108,965
Interest received	1,552	626	909	1,100	1,217	1,328
	1,715,300	1,836,581	1,945,710	2,030,095	2,117,916	2,198,691
Cash applied to:						
Payments to employees	760,305	822,566	895,964	945,495	994,158	1,038,865
Payments to suppliers	932,270	1,054,224	1,092,587	1,105,410	1,132,895	1,149,275
Capital charge and interest paid	30,352	211	54,464	69,518	72,672	77,458
GST - net	(1,338)	12,144	-	-	-	-
	1,721,589	1,889,145	2,043,015	2,120,423	2,199,725	2,265,598
Net Cash Flow from Operating Activities	**(6,289)**	**(52,564)**	**(97,305)**	**(90,328)**	**(81,809)**	**(66,907)**
CASH FLOW FROM INVESTING ACTIVITIES						
Cash provided from:						
Sale of property, plant, & equipment	460	123	-	-	-	-
Receipt from investments and restricted assets	43,758	-	-	-	-	-
	44,218	123	-	-	-	-
Cash applied to:						
Purchase of investments & restricted assets	43,158	1,087	-	-	-	-
Purchase of property, plant, & equipment	38,346	43,378	80,563	73,857	115,113	134,261
	81,504	44,465	80,563	73,857	115,113	134,261
Net Cash Flow from Investing Activities	**(37,286)**	**(44,342)**	**(80,563)**	**(73,857)**	**(115,113)**	**(134,261)**
CASH FLOW FROM FINANCING ACTIVITIES						
Cash provided from:						
Equity Injections						
Earthquake repair capital redrawn	9,258	1,104	29,000	5,000	47,692	-
Approved Mental Health Relocation DBC	-	-	7,503	26,114	31,050	14,333
Approved Facilities Redevelopment DBC (Note 7)	-	-	-	-	-	7,940
Operating deficit support	35,000	81,611	112,579	180,470	173,394	155,274
	44,258	82,715	149,082	211,584	252,136	177,547
Cash applied to:						
Annual depreciation funding repayment	1,861	1,861	1,861	1,861	1,861	1,861
	1,861	1,861	1,861	1,861	1,861	1,861
Net Cash Flow from Financing Activities	**42,397**	**80,854**	**147,221**	**209,723**	**250,275**	**175,686**
NET CASHFLOW						
Net increase/(decrease) in cash and cash equivalents	(1,178)	(16,052)	(30,647)	45,538	53,353	(25,482)
Cash and cash equivalents at beginning of year	(14,520)	(15,698)	(31,750)	(62,397)	(16,859)	36,494
Cash and cash equivalents at end of year	**(15,698)**	**(31,750)**	**(62,397)**	**(16,859)**	**36,494**	**11,012**

Note 7: Relates to balance of 2012/13 approved Facilities Redevelopment DBC funding (for Parkside). The $7.9M represents the original approved amount for Parkside of $21M less $13.06M transferred to Hagley building per 21 February Minister of Health letter advice. Assume as 'cash' transaction for transparency purpose only, until further advice is received.

4.18 Summary of revenue and expenses by arm

	2017/18 Actual $'000	2018/19 Forecast $'000	2019/20 Plan $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000
Funding Arm						
REVENUE						
Ministry of Health revenue	1,581,224	1,670,002	1,764,225	1,836,622	1,920,569	2,000,607
Other government revenue	2,713	2,916	2,269	2,050	2,132	2,218
Other revenue	927	1,250	1,452	1,452	1,452	1,452
Total Revenue	**1,584,864**	**1,674,168**	**1,767,946**	**1,840,124**	**1,924,153**	**2,004,277**
EXPENSE						
Personal Health	1,159,426	1,250,093	1,348,842	1,398,540	1,454,499	1,500,049
Mental Health	163,044	167,916	174,444	182,518	190,112	198,059
Disability Support	282,149	297,587	308,895	321,653	332,543	343,286
Public Health	4,438	4,469	4,417	3,796	3,913	4,027
Maori Health	1,856	1,958	2,111	2,126	2,190	2,252
Total Expense Before Depreciation & Capital Charge	**1,610,913**	**1,722,023**	**1,838,709**	**1,908,633**	**1,983,257**	**2,047,673**
Surplus/(Deficit) Before Depreciation & Capital Charge	**(26,049)**	**(47,855)**	**(70,763)**	**(68,509)**	**(59,104)**	**(43,396)**
Depreciation and amortisation	-	-	-	-	-	-
Capital charge and interest expense	-	-	-	-	-	-
Total Depreciation, Capital Charge & Interest Expense	**-**	**-**	**-**	**-**	**-**	**-**
Surplus/(Deficit)	**(26,049)**	**(47,855)**	**(70,763)**	**(68,509)**	**(59,104)**	**(43,396)**
Other comprehensive revenue and expense	-	-	-	-	-	-
Total Comprehensive Income/(Deficit)	**(26,049)**	**(47,855)**	**(70,763)**	**(68,509)**	**(59,104)**	**(43,396)**
Governance & Funder Admin						
REVENUE						
Ministry of Health revenue	3,992	4,139	4,061	4,267	4,460	4,663
Other government revenue	-	-	-	-	-	-
Other revenue	10	167	10	10	10	10
Total Revenue	**4,002**	**4,306**	**4,071**	**4,277**	**4,470**	**4,673**
EXPENSE						
Personnel	9,129	9,895	10,382	10,640	10,904	11,174
Outsourced	1,442	1,458	1,486	1,402	1,374	1,347
Clinical supplies	206	208	212	216	220	224
Earthquake Building Repair Costs	-	-	-	-	-	-
Infrastructure & non clinical (excl Earthquake repairs)	(5,754)	(8,602)	(8,369)	(8,341)	(8,388)	(8,432)
Payments to Non-DHB Providers	-	-	-	-	-	-
Total Expense Before Depreciation & Capital Charge	**5,023**	**2,959**	**3,711**	**3,917**	**4,110**	**4,313**
Surplus/(Deficit) Before Depreciation & Capital Charge	**(1,021)**	**1,347**	**360**	**360**	**360**	**360**
Depreciation and amortisation	362	292	360	360	360	360
Capital charge and interest expense	-	-	-	-	-	-
Total Depreciation, Capital Charge & Interest Expense	**362**	**292**	**360**	**360**	**360**	**360**
Surplus/(Deficit)	**(1,383)**	**1,055**	**-**	**-**	**-**	**-**
Other comprehensive revenue and expense	-	-	-	-	-	-
Total Comprehensive Income/(Deficit)	**(1,383)**	**1,055**	**-**	**-**	**-**	**-**

4.19 Summary of revenue and expenses by arm—continued

	2017/18 Actual $'000	2018/19 Forecast $'000	2019/20 Plan $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000
Provider Arm						
REVENUE						
Ministry of Health revenue	994,222	1,035,545	1,138,171	1,221,734	1,276,573	1,329,097
Other government revenue	34,235	34,071	36,509	37,946	39,464	41,042
Earthquake repair revenue redrawn	3,240	4,460	10,800	14,700	10,000	2,200
Other revenue	47,094	51,248	53,483	57,472	61,570	65,571
Total Revenue	**1,078,791**	**1,125,324**	**1,238,963**	**1,331,852**	**1,387,607**	**1,437,910**
EXPENSE						
Personnel	745,996	820,050	885,582	934,855	983,254	1,027,691
Outsourced	27,359	29,669	27,707	26,923	26,379	25,841
Clinical supplies	144,432	134,645	159,583	174,142	182,593	190,227
Earthquake building repair costs	3,240	4,460	10,800	14,700	10,000	2,200
Infrastructure & non clinical (excl Earthquake repairs)	105,645	123,733	127,729	133,893	135,774	138,364
Total Expense Before Depreciation & Capital Charge	**1,026,672**	**1,112,557**	**1,211,401**	**1,284,513**	**1,338,000**	**1,384,323**
Surplus/(Deficit) Before Depreciation & Capital Charge	**52,119**	**12,767**	**27,562**	**47,339**	**49,607**	**53,587**
Depreciation and amortisation	58,293	53,793	82,805	82,706	73,105	74,419
Capital charge and interest expense	30,353	24,753	54,464	69,518	72,672	77,458
Total Depreciation, Capital Charge & Interest Expense	**88,646**	**78,546**	**137,269**	**152,224**	**145,777**	**151,877**
Surplus/(Deficit)	**(36,527)**	**(65,779)**	**(109,707)**	**(104,885)**	**(96,170)**	**(98,290)**
OTHER COMPREHENSIVE REVENUE & EXPENSE						
Revaluation of property, plant & equipment	-	137,346	-	-	-	-
Total Comprehensive Income/(Deficit)	**(36,527)**	**71,567**	**(109,707)**	**(104,885)**	**(96,170)**	**(98,290)**
In House Elimination						
REVENUE						
Ministry of Health revenue	(931,556)	(965,570)	(1,065,270)	(1,146,158)	(1,198,314)	(1,248,169)
Total Revenue	**(931,556)**	**(965,570)**	**(1,065,270)**	**(1,146,158)**	**(1,198,314)**	**(1,248,169)**
EXPENSE						
Payments to internal providers	(931,556)	(965,570)	(1,065,270)	(1,146,158)	(1,198,314)	(1,248,169)
Total Expense	**(931,556)**	**(965,570)**	**(1,065,270)**	**(1,146,158)**	**(1,198,314)**	**(1,248,169)**
Surplus/(Deficit)	-	-		-	-	-
Other comprehensive revenue and expense	-	-	-	-	-	-
Total Comprehensive Income/(Deficit)	-	-	-	-	-	-

4.20 Summary of revenue and expenses by arm—continued

	2017/18 Actual $'000	2018/19 Forecast $'000	2019/20 Plan $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000
CONSOLIDATED						
REVENUE						
Ministry of Health revenue	1,647,882	1,744,116	1,841,187	1,916,465	2,003,288	2,086,198
Other government revenue	36,948	36,987	38,778	39,996	41,596	43,260
Earthquake repair revenue redrawn	3,240	4,460	10,800	14,700	10,000	2,200
Other revenue	48,031	52,665	54,945	58,934	63,032	67,033
Total Revenue	**1,736,101**	**1,838,228**	**1,945,710**	**2,030,095**	**2,117,916**	**2,198,691**
EXPENSE						
Personnel	755,125	829,945	895,964	945,495	994,158	1,038,865
Outsourced	28,801	31,127	29,193	28,325	27,753	27,188
Clinical supplies	144,638	134,853	159,795	174,358	182,813	190,451
Earthquake building repair costs	3,240	4,460	10,800	14,700	10,000	2,200
Infrastructure & non clinical (excl Earthquake repairs)	99,891	115,131	119,360	125,552	127,386	129,932
Payments to non-DHB providers	679,357	756,453	773,439	762,475	784,943	799,504
Total Expense Before Depreciation & Capital Charge	**1,711,052**	**1,871,969**	**1,988,551**	**2,050,905**	**2,127,053**	**2,188,140**
Surplus/(Deficit) Before Depreciation & Capital Charge	**25,049**	**(33,741)**	**(42,841)**	**(20,810)**	**(9,137)**	**10,551**
Depreciation and amortisation	58,655	54,085	83,165	83,066	73,465	74,779
Capital charge and interest expense	30,353	24,753	54,464	69,518	72,672	77,458
Total Depreciation, Capital Charge & Interest Expense	**89,008**	**78,838**	**137,629**	**152,584**	**146,137**	**152,237**
Surplus/(Deficit)	**(63,959)**	**(112,579)**	**(180,470)**	**(173,394)**	**(155,274)**	**(141,686)**
OTHER COMPREHENSIVE REVENUE & EXPENSE						
Revaluation of property, plant & equipment	-	137,346	-	-	-	-
Total Comprehensive Income/(Deficit)	**(63,959)**	**24,767**	**(180,470)**	**(173,394)**	**(155,274)**	**(141,686)**

APPENDICES

Further Information

5

Appendices

Appendix 1	Glossary of Terms
Appendix 2	Minister of Health's Letters of Expectation 2019/20
Appendix 3	Statement of Accounting Policies

Documents of interest

The following documents can be found on the Canterbury's DHB's website: www.cdhb.health.nz. Read in conjunction with this document, they provide additional context to the picture of health service delivery and transformation across the Canterbury health system.

- Canterbury DHB Annual Plan
- Canterbury System Level Measures Improvement Plan
- Canterbury DHB Public Health Action Plan
- Canterbury Disability Action Plan
- South Island Regional Health Services Plan
- Canterbury DHB Quality Accounts

References

Unless specifically stated, all Canterbury DHB documents referenced in this document are available on the Canterbury DHB website: www.cdhb.health.nz. Referenced regional documents are available from the South Island Alliance Programme Office website: www.siapo.health.nz. Referenced Ministry of Health documents are available on the Ministry's website: www.health.govt.nz. The Crown Entities Act 2004 and the Public Finance Act 1989, referenced in this document, are available on the Treasury website: www.treasury.govt.nz.

Appendix 1 Glossary of Terms

ADMS	Acute Demand Management Service	Refers to the service whereby general practice and acute community nursing deliver packages of care that enable people who would otherwise need an ED visit or hospital admission, to be treated in the community or in their own homes.
CCN	The Canterbury Clinical Network District Alliance	The CCN is a collective alliance of healthcare leaders, professionals and providers from across the Canterbury Health System. The Alliance provides leadership to enable the transformation of the health system in collaboration with system partners and on behalf of the population.
CREST	Community Rehabilitation Enablement and Support Team	Community Rehabilitation Enablement and Support Team supports the frail elderly who would otherwise be re-admitted to hospital or residential care. The Team is a collaboration across primary and secondary services and has been instrumental in reducing acute demand for hospital services and rates of aged residential care.
	Crown Entity	A generic term for a range of government entities that are legally separate from the Crown and operate at arm's length from the responsible or shareholding Minister, but are included in the financial statements of the Government.
ERMS	Electronic Referral Management System	ERMS is available from the GP desktop, and enables referrals to public hospitals and private providers to be sent and received electronically. Developed in Canterbury, it is now being rolled out South Island-wide and has streamlined the referral process by ensuring referrals are efficiently directed to the right place and receipt is acknowledged.
ESPIs	Elective Services Patient flow Indicators	The Elective Services Patient flow Indicators are a set of six indicators developed by the Ministry of Health to measure whether DHBs are meeting required performance standards in terms of the delivery of elective (non-urgent) services including wait times from referral to assessment and wait times from decision to treatment.
	Health Connect South	A shared regional clinical information system that provides a single repository for clinical records across the South Island. Already implemented in Canterbury, West Coast and South Canterbury, it is being rolled out across the rest of the South Island.
interRAI	International Resident Assessment Instrument	A suite of geriatric assessment tools that support clinical decision making and care planning by providing evidence-based practice guidelines and ensuring needs assessments are consistent and people are receiving equitable access to services. Aggregated data from the assessments is also used as a planning tool to improve the quality of health services and better target resources across the wider community according to need.
NHI	National Health Index	An NHI number is a unique identifier assigned to every person who uses health and disability services in NZ.
	Outcome	A state or condition of society, the economy or the environment, including a change in that state or condition (e.g. a change in the health status of a population).
PBF	Population-Based Funding	The national formula used to allocate each of the twenty DHBs a share of the available national health resources.
PHO	Primary Health Organisation	Funded by DHBs, PHOs ensure the provision of essential primary health care services to people who are enrolled with them, either directly or through its provider members (general practice). The aim is to ensure general practice services are better linked with other health services to ensure a seamless continuum of care.
	Public Health Services	The science and art of preventing disease, prolonging life and promoting health and efficiency through organised community effort.
	Secondary Care	Specialist care that is typically provided in a hospital setting.
	Primary Care	Professional health care received in the community, usually from a general practice team, covering a broad range of health and preventative services.
SIAPO	South Island Alliance Programme Office	A project office that supports the five South Island DHBs to work together to support the delivery of clinically and financially sustainable service across the South Island.
	Tertiary Care	Very specialised care often only provided in a smaller number of locations.

Appendix 2 Minister of Health's Letters of Expectation

Hon Dr David Clark

MP for Dunedin North

Minister of Health

Associate Minister of Finance

Dr John Wood
Canterbury District Health Board

12 JUL 2019

Tēnā koe John

UPDATE: Letter of Expectations for district health boards and subsidiary entities for 2019/20

This letter sets out an update to the Government's expectations for district health boards (DHBs) and their subsidiary entities for 2019/20. This builds on my December 2018 letter, attached for your reference. I want to emphasise that my strong focus remains on the expectations set out in that letter.

I also want to acknowledge your engagement with the important conversations we have been having on improving financial sustainability and clinical performance.

While I recognise there are a number of challenges, it is my expectation that DHBs ensure their local communities can access high quality sustainable services that deliver equitable outcomes.

Wellbeing Budget

Budget 2019 is about delivering better wellbeing for all New Zealanders and driving intergenerational change. There are five key priorities – taking mental health seriously, improving child poverty, supporting Māori and Pasifika aspirations, building a productive nation, and transforming the economy.

Budget 2019 builds on last year's Vote Health investment. A record $19.871 billion is being invested for 2019/20 to support a stronger, more sustainable health and disability system.

Our Government has signalled a willingness not just to invest, but also to make the fundamental changes needed to deliver long term and sustainable change. Budget initiatives are also based around evidence on what will make the greatest contribution to the long term improvement of living standards and wellbeing.

Monitoring improved performance

High performing DHBs are needed to support the delivery of the Government's priorities. I am concerned about the sector's overall financial position, and some areas of service performance.

As you are aware I have worked with the Ministry of Health (Ministry) to ensure DHB performance is supported through a stronger performance programme. This will help DHBs to be more sustainable, and to improve financial and clinical performance to ensure better and more equitable outcomes for New Zealanders. I have made it clear that you have a responsibility to address the range of performance challenges in partnership with the Ministry.

1

+64 4 817 8709 Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand d.clark@ministers.govt.nz beehive.govt.nz

Your DHB's performance will be reported to me regularly, and I support the use of data and benchmarking to identify variation as well as opportunities for improvement. This will also support collaboration across DHBs regionally and nationally to make the most of our collective capability. I expect all DHBs to contribute to, and participate in, such work to help ensure the system is safe, equitable, efficient, and maximises the resource use across the whole system.

Fiscal responsibility

I have made my expectations on improving financial performance very clear, and DHBs need to have a plan to return to financial sustainability.

You have been provided with your confirmed budget allocations for 2019/20 and I expect you to be considering ways to contain expenditure, including maximising available capability and resources in the system, tightly managing recruitment and staff leave, and improving consistency of clinical pathways and decision-making.

Continuing to do things in the same way as we are now is not sustainable operationally, clinically or financially. There will be a dedicated focus in 2019/20 on strengthening sustainability planning and establishing an on-going sustainability programme.

You will be aware that Budget 2019 invests an extra $94.7 million over four years to help improve DHB financial sustainability. This new funding will enable DHBs to work more collaboratively across your regions, to share and build on best practice, to implement new service models that transform the way we use workforce and facilities, and to make the best use of the available funding and capacity in your region.

Capital investment

Budget 2019 invests $1.7 billion over two years for capital investment projects, building on last year's investment to restore our hospitals and health facilities. This funding will be prioritised for mental health projects, high growth areas with increased demand, and health facilities that are no longer fit for purpose. I urge that in all investment, environmental sustainability be a significant consideration.

Some business cases for new infrastructure projects are already well advanced and have been indicatively prioritised for consideration. I expect this process to be completed with DHBs being advised of the outcomes in July/August 2019.

The Ministry of Business, Innovation and Employment is developing a new framework which will focus on skills development and training as a requirement of construction projects. New construction procurement guidelines will also be applied across government. I expect you to apply the changes to the procurement of new construction projects.

National Asset Management Plan

In the long term, we need to better map out future infrastructure requirements. This will enable the Government to make more informed decisions, and better prioritise remediation work and plan for new facilities.

I am pleased that you are actively supporting the National Asset Management Plan programme of work. I expect that any requests for information from the project team are responded to in a timely manner.

It is also my expectation that you will update your DHB's Asset Management Plans. These are a requirement of the Ministry, and will assist in the formulation of the capital investment pipeline, and the ongoing work on the National Asset Management Plan.

The Budget also provides some funding to lift capacity and capability within the Ministry, notably to establish a new health infrastructure unit that will provide better support to DHBs.

Update on my priority areas

Improving child wellbeing

As you know, child wellbeing is a key priority for this Government. I expect your annual plans to reflect how you are actively working to improve childhood immunisation coverage and eliminate inequity, especially for Māori.

As I have said in my earlier letter of expectations, I expect you to support the reduction of family violence and sexual violence through addressing abuse as a fundamental healthcare responsibility.

Improving mental wellbeing

Mental health and addiction is a top priority in the Wellbeing Budget with $1.9 billion over four years being invested into a range of mental wellbeing initiatives and mental health and addiction facilities. These strongly align with the Government's response to He Ara Oranga, the report of the independent inquiry into mental health and addiction.

We have a unique opportunity to improve the mental health and wellbeing of all New Zealanders. We need to embed a focus on wellbeing and equity at all points of the system. We also need to focus more on mental health promotion, prevention, identification, and early intervention.

It is my expectation that you will work closely with the Ministry and key partners in your region to help drive this transformation; your leadership is essential.

Improving wellbeing through prevention

Our Government's vision is for a welfare system that ensures people have an adequate income and standard of living, are treated with respect, can live in dignity and are able to participate meaningfully in their communities. DHBs have an important and ongoing role working alongside social sector partners to improve the welfare and health system outcomes for their population.

I have introduced a new priority section in DHB annual plans, given the considerable overlaps between people engaging with the welfare system as well as the health and disability support system. Over half the proportion of working age people receiving a main benefit have a health condition or a disability, or care for someone with a health condition or disability.

Better population health outcomes supported by a strong and equitable public health and disability system

Planned Care

I am confident that the changes to how planned care is planned, funded and monitored will remove the current disincentives to developing better ways of delivering services.

The new planned care approach will enable DHBs to deliver more appropriate, timely, high quality services to support the health and wellbeing of New Zealanders. DHBs will be able to provide care in the most appropriate setting, with the right workforce.

There will also be a greater focus on equity, quality, and people's experience of our services. I expect DHBs to create robust plans for these services and to consistently meet volume, waiting time, and other quality expectations.

Cancer Action Plan

I have asked the Ministry to work with you and other stakeholders to develop a Cancer Action Plan. I expect you to support and drive the development of this important work, and to deliver on the local actions within your Plan.

Health Research Strategy Implementation

Research, evidence and innovation is critical to addressing inequities and in continuously improving the quality and outcomes of services provided.

I am aware that the Ministry is working with DHBs and other government agencies to develop a work programme to implement the Health Research Strategy. I encourage you to continue to work closely with the Ministry to progress this important work.

Workforce

DHBs have a key role in training our health and disability workforce. I expect that all DHBs continue to maintain a strong focus on this area to build capacity and capability, and to implement an equitable approach to funding professional development.

In your current annual plan I expect you to develop a sustainable approach to nursing career pathways, including actions to support equitable funding for professional development for nurse practitioners.

Care Capacity Demand Management

At the end of last year I outlined my expectation that DHBs are to implement Care Capacity Demand Management (CCDM) in line with the process and timetable set out in the 2018-2020 MECA.

I expect to see significant progress on CCDM implementation this year, as well as detailed planning to ensure full implementation by June 2021.

I expect you to confirm that you have met my expectation to include implementing CCDM in the performance expectations of your Chief Executive and that you are updating these expectations to include implementation in midwifery services.

Devolution of the pay equity appropriation

I have supported the devolution of the pay equity appropriation. I expect you to work with the Ministry to ensure a seamless transition of responsibilities.

The Ministry has an ongoing stewardship responsibility to ensure that Care and Support Workers (Pay Equity) Settlement Act obligations are met.

The Government's agenda to improve the health and wellbeing of New Zealanders is significant, as evidenced by the sizable investments being made. I am confident that DHBs will present strong plans to support delivery of our priorities and I am looking forward to seeing progress against both measures and activities during the year.

I have appreciated the willingness shown by DHB teams to focus on equity and outcomes, and have confidence that you will all embrace the direction and implement plans to deliver it.

Thank you for your continued dedication and efforts to provide high quality and equitable health care and outcomes for New Zealanders.

Ngā mihi nui

Hon Dr David Clark
Minister of Health

Hon Dr David Clark

MP for Dunedin North
Minister of Health
Associate Minister of Finance

19 DEC 2018

Dr John Wood
Chair
Canterbury District Health Board

Dear John

Letter of Expectations for district health boards and subsidiary entities for 2019/20

This letter sets out the Government's expectations for district health boards (DHBs) and their subsidiary entities for 2019/20.

In early September, the Prime Minister announced a long-term plan to build a modern and fairer New Zealand; one that New Zealanders can be proud of. As part of the plan, our Government commits to improving the wellbeing of all New Zealanders and their families, and ensuring that the economy is growing and working for all.

Our health system has an important role in supporting the Government's goals. To do this we need to be sure that our public health system is: strong and equitable, performing well, and focused on the right things to make all New Zealanders' lives better.

Achieving equity within the New Zealand health system underpins all of my priorities. Māori as a population group experience the poorest health outcomes. As you consider equity within your district, there needs to be an explicit focus on achieving equity for Māori across their life course. Māori-Crown relations is a priority for this Government and I expect your DHB to meet your Treaty of Waitangi obligations as specified in the New Zealand Public Health and Disability Act 2000. I am expecting you to report on progress with how you are meeting these obligations as part of your Annual Plan reporting.

Unmet need also represents a significant barrier to achieving equity in health outcomes for all populations groups across New Zealand. I expect your Annual Plan to contain actions that will enable progress towards achieving equity and to address the key areas of unmet need especially for Pacific peoples and other population groups in your regions with poorer health outcomes.

Our approach

DHB Chairs are directly accountable for their DHB's performance. We expect Boards to be highly engaged and to hold Chief Executives and management to account for improved performance within their DHB, in relation to both equity of access to health services and equity of health outcomes. In addition, I will also be working towards ensuring that Māori membership of DHB Boards is proportional to the Māori population within your district.

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Fiscal responsibility
Strong fiscal management is essential to enable delivery of better services and outcomes for New Zealanders. I expect DHBs to live within their means and maintain expenditure growth in line with or lower than funding increases.

My expectation is that DHBs have in place clear processes to ensure appropriate skill mix and FTE growth that supports changes in models of care and use the full range of the available workforce and settings. This is essential for ensuring financial and clinical sustainability of our health system.

A better collective understanding of the demand for services, drivers of deficits and financial risks remains a very significant priority and I expect you to work closely and proactively with the Ministry of Health on these matters. I will continue to meet and speak with you frequently during the year to discuss performance, and I will be looking particularly closely at your ability to deliver in the Government's priority areas, to keep within budget and to manage your cash position.

Strong and equitable public health and disability system

Building infrastructure
My expectation is for timely delivery of Ministers' prioritised business cases. I remind you that capital projects over $10 million are subject to joint Ministers (Minister of Health and Minister of Finance) approval. Business cases will be assessed to ensure that they are in line with the Health Capital Envelope priorities. I also expect you ensure that your agency is aware of the expectation that upcoming construction projects will be used to develop skills and training and that the construction guidelines will be applied for all procurement of new construction from this point onwards. I will be writing to you separately about this with further detail.

National Asset Management Plan
I expect you to support the National Asset Management Plan programme of work. I encourage you to actively interact with the project as, long term, the National Asset Management Plan will formulate the capital investment pipeline, and ensure DHBs' future infrastructure needs are met.

Devolution
I am considering devolution of certain services and expect to be making decisions in the New Year. DHBs will be consulted during the process to ensure the financial and service implications are well understood. Once any decisions have been made, I will expect you to work with the Ministry of Health to ensure a seamless transition of responsibilities.

Workforce
I expect DHBs to develop bargaining strategies that are consistent with the Government Expectations on Employment Relations in the State Sector, and to act collaboratively to ensure that any potential flow-on implications across workforces and/or across DHBs are understood and addressed in the bargaining strategies. A Government priority is raising the wages of the least well-paid workforces, which will require a different approach to the traditional one based on across-the-board percentage increases. I also expect DHBs to implement Care Capacity Demand Management in accordance with the process and timetable set out in the 2018-2020 MECA. I note that the State Services Commissioner has included wording that reflects the commitments in the New Zealand Nurses Organisation Accord in the performance expectations of the Director-General of Health and I ask you to consider including similar wording in the performance expectations of your Chief Executive.

DHBs have an essential role in training our future workforce and I expect you to support training opportunities for the range of workforce groups. As part of this, you should work closely with training bodies such as tertiary education institutes and professional colleges and bodies to ensure that we have a well trained workforce and to support research. I continue to expect DHBs will adhere to the Medical Council's requirement for community-based attachments for PGY1 and PGY2 doctors.

Bowel Screening
The National Bowel Screening programme remains a priority for this Government, and I expect you to develop a sustainable endoscopy workforce, be it medical or nursing, including the strategic support of training positions for both nursing and medical trainees in order to meet growing demand in this area. It is crucial that symptomatic patients are not negatively impacted by screening demand and the Ministry of Health will work closely with you on workforce issues to support this.

Planned Care
I am enabling DHBs to take a refreshed approach to the delivery of elective services under a broader "Planned Care" programme. Timely access to Planned Care remains a priority. The refreshed approach to Planned Care will provide you with greater flexibility in where and how you deliver services and will enable more care to be delivered within the funding envelope. I urge you to take advantage of the opportunity that will be made available, and support your teams to develop well considered delivery plans that align with your population's needs, support timely care, and make the best use of your workforce and resources.

Disability
Disabled people experience significant health inequalities and they should be able to access the same range of health services as the rest of the general population. My expectation is that DHBs are working towards or are implementing the Convention on the Rights of Persons with Disabilities. I expect DHBs to implement policies for collecting information, within their populations, about people with disabilities. In addition, please ensure your contracts with providers reflect their requirements to either ensure accessibility or put in place concrete plans to transition to a more accessible service.

System Level Measures
As part of your focus on improving quality, I expect you to continue to co-design and deliver initiatives to achieve progress on System Level Measures with primary health organisations (PHOs) and other key stakeholders.

Rural health
The Government expects DHBs with rural communities to consider their health needs and the factors affecting health outcomes for rural populations when making decisions regarding health services.

Mental health and addiction care

Mental health and addiction remains a priority area for this Government and I expect your DHB to prioritise strengthening and improving mental health and addiction service areas in your 2019/20 Annual Plan. The Mental Health and Addiction Inquiry report is under consideration by the Government and it is my expectation that DHBs are ready to move on implementing the Government's response to its recommendations.

Over the last year a number of deaths across the country have been attributed to use of synthetic cannabinoids. I expect DHBs to consider the role of both public health and specialist treatment services in providing coordinated local responses to emerging drug threats such as synthetic cannabinoids.

Child wellbeing

Child wellbeing is a priority for our Government. I expect your annual plans to reflect how you are actively working to improve the health and wellbeing of infants, children, young people and their whānau with a particular focus on improving equity of outcomes.

In supporting the Government's vision of making New Zealand the best place in the world to be as a child I expect DHBs to have a specific focus on:

- supporting the development of the Child Wellbeing Strategy, particularly the First 1000 days of a child's life and child and youth mental wellbeing
- contributing to the review of the Well Child Tamariki Ora programme
- supporting the reduction of family violence and sexual violence through addressing abuse as a fundamental health care responsibility.

Maternity care and midwifery
High quality maternity care is recognised as a fundamental part of child wellbeing. I am listening to the issues the community is raising with me, and I take the concerns about the level of capacity in the midwifery workforce seriously. It is my expectation that DHBs implement a plan to support improved recruitment and retention of midwives, including midwives in the community and midwives employed in all maternity facilities.

Smokefree 2025
I also expect you to advance progress towards the Smokefree 2025 goal, particularly community-based wrap-around support for people who want to stop smoking, with a focus on Māori, Pacific, pregnant women and people on a low income. I also want to see DHBs collaborating across their region to support smoking cessation including, where appropriate, amongst programme providers, with a view to sharing and strengthening knowledge and delivery of effective interventions.

Primary health care

Improved access to primary health care brings significant benefits for all New Zealanders as well as our health system. Removing barriers to primary health care services and improving equity are key priorities for this Government. I also want to see closer integration of primary health care with secondary and community care. I intend to continue to invest in primary health care and expect all DHBs to support this important priority.

Non-communicable disease (NCD) prevention and management

As our major killers, NCDs, particular cancers, cardiovascular disease and type 2 diabetes need to be a major focus for prevention and treatment for your DHB. I want you to continue a particular focus on type 2 diabetes prevention and management, including an emphasis on ensuring access to effective self-management education and support. I want to see an increased focus on prevention, resilience, recovery and wellbeing for all ages, as part of a healthy ageing approach. You should also use PHO and practice-level data to inform quality improvement.

Public health and the environment

Environmental sustainability
I expect you to continue to contribute to the Government's priority outcome of environmental sustainability and undertake further work that leads to specific actions, including reducing

carbon emissions, to address the impacts of climate change on health. This will need to incorporate both mitigation and adaption strategies, underpinned by cost-benefit analysis of co-benefits and financial savings and I expect you to work collectively with the Ministry of Health on this important area.

Healthy eating and healthy weight
As part of your sector leadership role, I strongly encourage you to support healthy eating and healthy weight through continuing to strengthen your DHB's Healthy Food and Drink Policy This includes increasing the number of food options categorised as 'green' in the National Policy and moving towards only selling water and milk as cold drink options. I actively encourage you to support other public and private organisations to do the same. There is a strong rationale for DHBs providing such leadership in their communities to both set an example and to 'normalise' healthy food and drink options. In particular I would like you to work directly with schools to support them to adopt water-only and healthy food policies.

Drinking water
You will be aware that our Government is undertaking system-wide reform of the regulatory arrangements for drinking water and I am confident that you will support any developments that may result. I expect you to work through your Public Health Unit across agency and legislative boundaries to carry out your key role in drinking water safety with a focus on the health of your population.

Integration
Improving equity and wellbeing and delivering on several other expectations I am setting in this letter will not be possible without strong cross-sectoral collaboration. I expect DHBs to demonstrate leadership in the collaboration between and integration of health and social services, especially housing.

Planning processes

Your DHB's 2019/20 Annual Plan is to reflect my expectations and I also ask you to demonstrate a renewed focus on your strategic direction, by refreshing your Statement of Intent in 2019/20.

I believe providing you with my expectations in December will support your planning processes, however I also acknowledge that some important decisions will be made in the coming weeks, including detail related to implementation of the Mental Health and Addictions Inquiry recommendations. To ensure my expectations are clear, it is my intention to provide an update to this letter in the New Year.

I would like to take this opportunity to thank you, the Board and your staff for your dedication and efforts to provide high quality and equitable outcomes for your population.

Yours sincerely

Hon Dr David Clark
Minister of Health

Appendix 3 Statement of Accounting Policies

10.13 Statement of accounting policies

The prospective financial statements in Canterbury DHB's Annual Plan and Statement of Intent for the year ended 30 June 2019 are prepared in accordance with Section 38 of the Public Finance Act 1989 and they comply with NZ IFRS, as appropriate for public benefit entities. PBE FRS42 states that the (prospective) forecast statements for an upcoming financial year should be prepared using the same standards as the statements at the end of that financial year.

The following information is provided in respect of this Plan:

(i) Cautionary Note

The financial information presented is prospective. Actual results are likely to vary from the information presented, and the variations may be material.

(ii) Nature of Prospective Information

The financial information presented consists of forecasts that have been prepared on the basis of best estimates and assumptions on future events that Canterbury DHB expects to take place.

(iii) Assumptions

The main assumptions underlying the forecast are noted in Section 8 of the Annual Plan.

STATEMENT OF ACCOUNTING POLICIES

REPORTING ENTITY AND STATUTORY BASE

Canterbury DHB is a district health board established by the New Zealand Public Health and Disability Act 2000. The Canterbury DHB is a Crown entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand.

Canterbury DHB has designated itself and its subsidiaries, as public benefit entities (PBEs) for financial reporting purposes.

The consolidated financial statements of Canterbury DHB consist of Canterbury DHB and its subsidiaries:

- Canterbury Linen Services Ltd (100% owned)
- Brackenridge Services Ltd (100% owned)

Canterbury DHB's primary objective is to deliver health and disability services and mental health services in a variety of ways to the Canterbury community. Canterbury DHB does not operate to make a financial return.

BASIS OF PREPARATION

Statement of Going Concern

The financial statements have been prepared on a going concern basis, and the accounting policies have been applied consistently throughout the period.

Statement of Compliance

The consolidated financial statements have been prepared in accordance with the requirements of the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004, which includes the requirement to comply with New Zealand generally accepted accounting practice (NZ GAAP).

The financial statements have been prepared in accordance with Tier 1 PBE accounting standards.

Measurement Basis

The financial statements are prepared on the historical cost basis except that land and buildings are stated at their fair values.

Functional and Presentation Currency

The financial statements are presented in New Zealand dollars (NZD), rounded to the nearest thousand dollars. The functional currency of Canterbury DHB is NZD.

Changes in Accounting Policies

The accounting policies set out below have been applied consistently to all periods presented in these consolidated financial statements.

SIGNIFICANT ACCOUNTING POLICIES

Basis for Consolidation

The purchase method is used to prepare the consolidated financial statements, which involves adding together like items of assets, liabilities, equity, revenue and expenses on a line-by-line basis. All significant intragroup balances, transactions, revenue and expenses are eliminated on consolidation.

Budget Figures

The budget figures are those that are approved by the Board of Canterbury DHB in its Statement of Performance Expectations. The budget figures have been prepared in accordance with NZ GAAP, using accounting policies that are consistent with those adopted by Canterbury DHB for the preparation of these financial statements.

Income Tax

Canterbury DHB is a crown entity under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under section CW38 of the Income Tax Act 2007.

Goods and Services Tax

All amounts are shown exclusive of Goods and Services Tax (GST), except for receivables and payables that are stated inclusive of GST. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.

The net GST paid to, or received from Inland Revenue, including the GST relating to investing and financing activities, is classified as a net operating cash flow in the statement of cash flows. Commitments and contingencies are disclosed as exclusive of GST.

Critical Accounting Estimates and Assumptions

The preparation of financial statements in conformity with International Public Sector Accounting Standards (IPSAS) requires management to make judgements, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, revenue and expenses. The estimates and associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances, the results of which form the basis of making the judgements about carrying values of assets and liabilities that are not readily apparent from other sources. These estimates and assumptions may differ from the actual results. The estimates and underlying assumptions are reviewed on an ongoing basis.

The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amount of assets and liabilities within the next financial year are highlighted in the following notes.

Standards Issued but Not Yet Effective and Not Early Adopted

Standards and amendments, issued but not yet effective that have not been early adopted, and which are relevant to Canterbury DHB are:

Service performance reporting

In November 2017, the XRB issued PBE FRS 48 Service Performance Reporting. The new standard is effective for annual periods beginning on or after 1 January 2021 with early application permitted. The new standard establishes requirements for PBEs to select and present service performance information. Entities will provide users with:

- Sufficient contextual information to understand why the entity exists, what it intends to achieve in broad terms over the medium to long term, and how it goes about this; and
- Information about what the entity has done during the reporting period in working towards its broader aims and objectives.

Canterbury DHB plans to apply this standard in preparing the 30 June 2022 financial statements. Canterbury DHB has not yet assessed the effects of the new standard.

Interests in other entities

In January 2017, the XRB issued new standards for interests in other entities (PBE IPSAS 34 - 38). These new standards replace the existing standards for interests in other entities (PBE IPSAS 6 - 8). The new standards are effective for annual periods beginning on or after 1 January 2019, with early application permitted. The DHB plans to apply the new standards in preparing the 30 June 2020 financial statements. The DHB has not yet assessed the effects of these new standards.

Revenue

Ministry of Health population-based funding

Canterbury DHB receives annual funding from the Ministry of Health, which is based on population levels within the Canterbury DHB region.

Ministry of Health population-based revenue for the financial year is recognised based on the funding entitlement for that year.

Inter-district flows

Inter-district patient inflow revenue occurs when a patient treated within Canterbury DHB's district is domiciled outside of the district. Inter-district patient inflow revenue is recognised when eligible services are provided.

Ministry of Health other contracts

The revenue recognition approach for Ministry of Health contract revenue depends on the contract terms. Those contracts where the amount of revenue is substantively linked to the provision of quantifiable units of service are treated as exchange contracts and revenue is recognised as Canterbury DHB provides the services.

Other contracts are treated as non-exchange and the total funding receivable under the contract is recognised as revenue immediately, unless there are substantive conditions in the contract. If there are substantive conditions, revenue is recognised when the conditions are satisfied. A condition could include the requirement to provide services to the satisfaction of the Ministry of Health to receive or retain funding.

Revenue for future periods is not recognised where the contract contains substantive termination provisions for failure to comply with the service requirements of the contract. Conditions and termination provisions need to be substantive, which is assessed by considering factors such as the past practice of the Ministry of Health. Judgement is often required in determining the timing of revenue recognition for contracts that span a balance date and multi-year funding arrangements.

ACC revenue

ACC contract revenue is recognised as revenue when eligible services are provided and any contract conditions have been fulfilled.

Provision of other services

Revenue derived through the provision of other services to third parties is recognised in proportion to the stage of completion at the balance date, based on the actual service provided as a percentage of the total services to be provided.

Donations and bequests

Donations and bequests received with restrictive conditions are treated as a liability until the specific terms from which the funds were derived are fulfilled. Until the conditions attached have been fulfilled, the assets received are treated as restricted assets.

Vested or donated physical assets

For assets received for no or nominal consideration, the asset is recognised at its fair value when Canterbury DHB obtains control of the asset. The fair value of the asset is recognised as revenue, unless there is a use or return condition attached to the asset.

The fair value of vested or donated assets is usually determined by reference to the cost of purchasing the asset if the asset is new, or reference to market information for assets of a similar type, condition, or age for used assets.

Donated services

Volunteer services received are not recognised as revenue or expenses by Canterbury DHB.

Estimates and assumptions: Non-government grants

Canterbury DHB must exercise judgement when recognising grant revenue to determine if conditions of the grant contract have been satisfied. This judgement will be based on the facts and circumstances that are evident for each grant contract.

Operating Lease Payments

Payments made under operating leases are recognised in the surplus or deficit on a straight-line basis over the term of the lease. Lease incentives received are recognised in the surplus or deficit over the lease term as an integral part of the total lease expense.

Equity

Equity is measured as the difference between total assets and total liabilities.

In accordance with IPSAS 1, repayments of capital to the Crown, as well as contributions from the Crown under Vote Health capital appropriations are recorded in contributed capital.

Revaluation reserve

This reserve relates to the revaluation of property, plant and equipment to fair value.

Cash and Cash Equivalents

Bank term deposits

Investments in bank term deposits are measured at the amount invested.

Cash and cash equivalents

Cash and cash equivalents comprises cash balances, call deposits and deposits with a maturity of no more than three months from the date of acquisition.

Trade and Other Receivables

Trade and other receivables are non-interest bearing and receipt is normally within 30-day terms. Therefore, the carrying value of receivables approximates their fair value. Trade and other receivables are subsequently stated at amortised cost less any provision for impairment. Bad debts are written off during the period in which they are identified. A receivable is considered impaired when there is evidence that Canterbury DHB will not be able to collect the amount due. The amount of the impairment is the difference between the carrying amount of the receivable and the present value of the amounts expected to be collected.

Inventories

No inventories are pledged as security for liabilities; however, some inventories are subject to retention of title clauses.

Inventories held for distribution, or consumption in the provision of services, that are not issued on a commercial basis are measured at cost (calculated using the weighted average cost method) adjusted when applicable for any loss of service potential. Inventories acquired through non-exchange transactions are measured at fair value at the date of acquisition.

Other inventories are stated at cost (calculated using the weighted average method).

The amount of any write-down for the loss of service potential or from cost to net realisable value is recognised in the surplus or deficit in the period of the write-down.

Provisions

A provision is recognised when Canterbury DHB has a present legal or constructive obligation as a result of a past event, and it is probable that expenditures will be required to settle the obligation. If the effect is material, provisions are determined by discounting the expected future cash flows at a pre-tax rate that reflects current market rates and, where appropriate, the risks specific to the liability.

Employee entitlements

Defined contribution plans

Obligations for contributions to defined contribution plans are recognised as an expense in the surplus or deficit as incurred.

Defined benefit plans

Canterbury DHB makes contributions to the Defined Benefit Plan Contributors Scheme (the scheme), which is a multi-employer defined benefit scheme.

Insufficient information is available to use defined benefit accounting, as it is not possible to determine from the terms of the scheme, the extent to which the surplus or deficit will affect future contributions by individual employers, as there is no prescribed basis for allocations. The scheme is therefore accounted for as a defined contribution scheme.

Long service leave, sabbatical, retirement gratuities and sick leave

Canterbury DHB's net obligation in respect of long service leave, sabbatical leave and retirement gratuities is the amount of future benefit that employees have earned in return for their service in the current and prior periods. The obligation is calculated using the projected unit credit method including a salary inflation factor and is discounted to its present value. The discount rate is the market yield on relevant New Zealand government bonds at the year-end date. Canterbury DHB accrues the obligation for paid absences when the obligation both relates to employees' past services and it accumulates. The sick leave amount is calculated based on the unused sick leave entitlement that can be carried forward at balance date to the extent that Canterbury DHB anticipates it will be used by staff to cover those future absences.

Annual leave, conference leave and medical education leave

Annual leave, conference leave and medical education leave are short-term obligations and are measured at undiscounted nominal values based on accrued entitlements at current rates for pay.

Presentation of employee entitlements

Non-vested long service leave and retirement gratuities are classified as non-current liabilities; all other employee entitlements are classified as current liabilities.

ACC Partnership Programme

Canterbury DHB belongs to the ACC Partnership Programme whereby the DHB accepts the management and financial responsibility for employee work-related illnesses and accidents. Under the programme Canterbury DHB is liable for all its claims costs for a period of five years up to a specified maximum. At the end of the five year period, Canterbury DHB pays a premium to ACC for the value of residual claims, and from that point the liability for ongoing claims passes to ACC.

The liability for the ACC Partnership Programme is measured using actuarial techniques at the present value of expected future payments to be made in respect of the employee injuries and claims up to the reporting date. Consideration is given to anticipated future wage and salary levels and experience of employee claims and injuries. Expected future payments are discounted using market yields on government bonds at balance date with terms to maturity that match, as closely to possible, the estimated future cash outflows.

Estimates and assumptions: Retirement and long service leave

The present value of the retirement and long service leave obligations depend on a number of factors that are determined on an actuarial basis using a number of assumptions. Two key assumptions used in calculating this liability include the discount rate and the salary inflation factor. Any change in these assumptions will impact on the carrying amount of the liability.

Property, plant and equipment

Owned assets

Except for land and buildings, and the assets vested from the Crown, items of property, plant and equipment are stated at cost, less accumulated depreciation and impairment losses.

Revaluations

Land, buildings and building fitout (excluding leased building fitout) are revalued to fair value as determined by an independent registered valuer, with sufficient regularity to ensure the carrying amount is not materially different to fair value, and at least every five years. Any increase in value of a class of land and buildings is recognised directly to equity unless it offsets a previous decrease in value recognised in the statement of comprehensive revenue and expense. Any decreases in value relating to land and buildings are debited directly to the revaluation reserve, to the extent that they reverse previous surpluses and are otherwise recognised as an expense in other comprehensive revenue. Additions to land and buildings between valuations are recorded at cost.

The carrying values of revalued assets are assessed annually to ensure that they do not differ materially from fair value. If there is evidence supporting a material difference, then the off-cycle asset classes are revalued.

Land and building revaluation movements are accounted for on a class-of-asset basis.

Disposal of property, plant and equipment

Where an item of plant and equipment is disposed of, the gain or loss is recognised in the surplus or deficit. It is calculated as the difference between the net sales price and the carrying amount of the asset.

When revalued assets are sold, the amounts included in revaluation reserves in respect of those assets are transferred to general funds.

Depreciation

Depreciation is charged to the surplus or deficit using the straight line method so as to write off the cost or valuation of fixed assets above $2,000 to their estimated residual value over their expected economic life. Assets below $2,000 are written off in the month of purchase. Land is not depreciated.

The estimated useful lives of major classes of assets and resulting rates are as follows:

Type of asset	Useful life	Depreciation rate
Buildings structure	**35 – 90**	**1.1 – 2.9%**
Buildings infrastructure & fitout	**15 - 60**	**1.7 – 6.7%**
Temporary buildings	**2 - 20**	**5.0 – 50.0%**
Leasehold improvements	**3 - 30**	**3.3 – 33.3%**
Plant, equipment & vehicles	**3 - 20**	**5.0 – 33.3%**

The residual value and useful life of assets are reviewed, and adjusted if applicable, annually.

Additions

The cost of an item of property, plant and equipment is recognised as an asset only when it is probable that future economic benefits or service potential associated with the item will flow to Canterbury DHB and the cost of the item can be measured reliably.

Where material parts of an item of property, plant and equipment have different useful lives, they are accounted for as separate components of property, plant and equipment.

Work in progress is recognised at cost less impairment and is not depreciated.

Subsequent costs

Subsequent costs are added to the carrying amount of an item of property, plant and equipment when that cost is incurred if it is probable that the service potential or future economic benefits embodied within the new item will flow to Canterbury DHB. All other costs are recognised in the surplus or deficit when incurred.

Acquired computer software licences are capitalised on the basis of the costs incurred to acquire and bring to use the specific software.

Estimates and assumptions: Useful lives and residual value

At each balance date Canterbury DHB reviews the useful lives and residual values of its property, plant and equipment. Assessing the appropriateness of useful life and residual value estimates of property,

plant and equipment requires Canterbury DHB to consider a number of factors such as the physical condition of the asset, expected period of use of the asset by Canterbury DHB, advances in medical technology, and expected disposal proceeds from the future sale of the assets.

An incorrect estimate of the useful life or residual value will impact the depreciation expense recognised in the surplus or deficit, and carrying amount of the asset in the statement of financial position. Canterbury DHB minimises the risk of this estimation uncertainty by:

- Physical inspection of assets
- Asset replacement programs
- Review of second hand market prices for similar assets
- Analysis of prior asset sales

In light of the Canterbury earthquakes, Canterbury DHB continuously reviews the carrying value of land and buildings.

Intangible assets

Software development and acquisition

Expenditure on software development activities, resulting in new or substantially improved software and processes, is capitalised if the product or process is technically and operationally feasible and Canterbury DHB has sufficient resources to complete development. The expenditure capitalised includes the cost of materials, direct labour and an appropriate proportion of overheads. Staff training and other costs associated with maintaining computer software are recognised as an expense when incurred. Capitalised development expenditure is stated at cost less accumulated amortisation and impairment losses.

Amortisation

Amortisation is charged to the surplus or deficit on a straight-line basis over the estimated useful lives of intangible assets with finite lives. Such intangible assets are amortised from the date they are available for use. The estimated useful lives are as follows:

Type of asset	Estimated life	Amortisation rate
Software	3-20 years	5% – 33.3%

The residual value and useful life of assets are reviewed, and adjusted if applicable, annually.

Non-cash-generating assets

Property, plant, and equipment and intangible assets held at cost that have a finite useful life are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable service amount. The recoverable service amount is the higher of an asset's fair value less costs to sell and value in use.

Value in use is determined using an approach based on either a depreciated replacement cost approach, restoration cost approach, or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and availability of information. If an asset's carrying amount exceeds its recoverable service amount, the asset is regarded as impaired and the carrying amount is written-down to the recoverable amount. The total impairment loss is recognised in other comprehensive revenue and expense.

The reversal of an impairment loss is recognised in other comprehensive revenue and expense.

Impairment

The carrying amounts of Canterbury DHB's assets other than inventories are reviewed at each balance date to determine whether there is any indication of impairment. If any such indication exists, the assets' recoverable amounts are estimated.

If the estimated recoverable amount of an asset is less than its carrying amount, the asset is written down to its estimated recoverable amount and an impairment loss is recognised in the surplus or deficit.

An impairment loss on property, plant and equipment revalued on a class-of-asset basis is recognised directly against any revaluation reserve in respect of the same class of asset to the extent that the impairment loss does not exceed the amount in the revaluation reserve for the same class of asset, at which point it is recognised in the surplus or deficit.

When a decline in the fair value of an available-for-sale financial asset has been recognised directly in equity and there is objective evidence that the asset is impaired, the cumulative loss that had been recognised directly in equity is recognised in other comprehensive revenue and expense even though the financial asset has not been derecognised. The amount of the cumulative loss that is recognised in other comprehensive revenue and expense is the difference between the acquisition cost and current fair value, less any impairment loss on that financial asset previously recognised in other comprehensive revenue and expense.

The estimated recoverable amount of receivables carried at amortised cost is calculated as the present value of estimated future cash flows, discounted at their original effective interest rate. Receivables with a short duration are not discounted.

Estimated recoverable amount of other assets is the greater of their fair value less costs to sell and value in use. The value in use is the depreciated replacement cost for an asset where the future economic benefits or service potential of the asset are not primarily dependent on the asset's ability to generate net cash inflows and where Canterbury DHB would, if deprived of the asset, replace its remaining future economic benefits or service potential.

The reversal of an impairment loss on a revalued asset is credited to the revaluation reserve. However, to the extent that an impairment loss for that class of asset was previously recognised in other comprehensive revenue and expense, a reversal of the impairment loss is also recognised in other comprehensive revenue and expense.

Impairment losses are reversed when there is a change in the estimates used to determine the recoverable amount. An impairment loss is reversed only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised.

Borrowings

Borrowings are recognised initially at fair value plus transaction costs. Subsequent to initial recognition, borrowings are stated at amortised cost using the effective interest method.

Borrowings are classified as current liabilities unless Canterbury DHB has an unconditional right to defer settlement of the liability for at least 12 months after balance date.

Commitments

Estimates and assumptions: Leases classification

Determining whether a lease agreement is a finance or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards of ownership to Canterbury DHB.

Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term and determining an appropriate discount rate to calculate the present value of the minimum lease payments. Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant and equipment, whereas for an operating lease no such asset is recognised.

Canterbury DHB has exercised its judgement on the appropriate classification of its leases and has determined all lease arrangements are operating leases.

Foreign Currency

Transactions in foreign currencies are translated at the foreign exchange rate ruling at the date of the transaction.

Monetary assets and liabilities denominated in foreign currencies at the balance sheet date are translated to NZD at the foreign exchange rate ruling at that date. Foreign exchange differences arising on translation are recognised in the surplus /deficit.

Related Parties

Subsidiaries

Subsidiaries are entities controlled by Canterbury DHB. Control exists when Canterbury DHB has the power, directly or indirectly, to govern the financial and operating policies of an entity so as to obtain benefits from its activities. In assessing control, potential voting rights that presently are exercisable or convertible are taken into account. The financial statements of subsidiaries are included in the consolidated financial statements from the date that control commences until the date that control ceases.

Transactions eliminated on consolidation

Intragroup balances and any unrealised gains and losses or revenue and expenses arising from intragroup transactions, are eliminated in preparing the consolidated financial statements.

Associates

Associates are those entities in which Canterbury DHB has significant influence, but not control, over the financial and operating policies.

STATEMENT OF INTENT

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